Judith Richter

Public-Private Partnerships and International Health Policy-making

How can public interests be safeguarded?

PUBLIC-PRIVATE PARTNERSHIPS AND INTERNATIONAL HEALTH POLICY-MAKING

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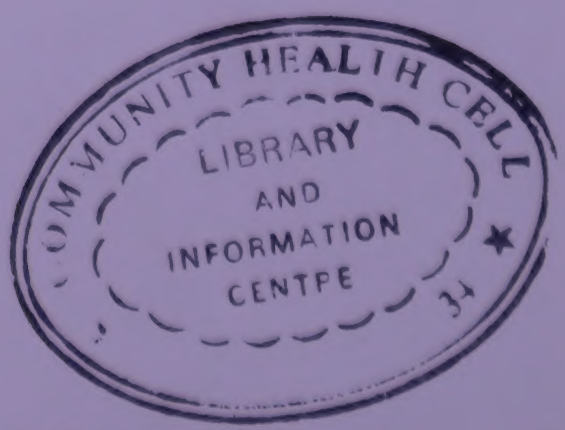

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About the author

Judith Richter, independent researcher and author, has worked on international health issues since the mid-1980s when she taught community pharmacy in Thailand. Much of her work has focused on exploring the interactions between UN agencies, governments, citizen action groups and transnational corporations. She has acted as research consultant to UNICEF, the World Health Organization, and various public interest NGOs. Judith Richter has a multidisciplinary background. She holds a PhD in Social Sciences, an MA in Development Studies, and a BSc in Pharmaceutical Sciences. She has also been trained in ethics in the sciences and humanities.

List of acronyms and abbreviations

AAI	Accelerated Access Initiative
BINGOs	Business interest NGOs
CMH	Commission on Macroeconomics and Health
CPSC	Committee on Private Sector Collaboration
CSO	Civil society organisation
CSR	Corporate social responsibility
CSPI	Center for Science in the Public Interest
GAIN	Global Alliance for Improved Nutrition
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight Aids, Tuberculosis and Malaria
HAI	Health Action International
HFA	Health for All
IARC	International Agency for Research on Cancer
IBFAN	International Baby Food Action Network
ICC	International Chamber of Commerce
IOE	International Organisation of Employers
IFM	International Association of Infant Food Manufacturers
IFPMA	International Federation of Pharmaceutical Manufacturers Associations
INFACT	Infant Formula Action Coalition
ISDI	International Special Dietary Foods Industries (current name)
MSD	Merck, Sharp & Dohme
NIEO	New International Economic Order
NGO	Nongovernmental organisation
PHM	Peoples' Health Movement
PINGOs	Public interest NGOs
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNF	UN Foundation
UNICEF	United Nations Children's Fund
UNFIP	UN Fund for International Partnerships
UNFPA	United Nations Population Fund
UNOSG	Office of the UN Secretary-General
UNOPS	United Nations Office for Project Services
UNRISD	United Nations Research Institute for Social Development
TCDC	Technical cooperation among developing countries
TNC	Transnational corporation
WEF	World Economic Forum

Introduction

Public-private partnerships (PPPs) are being promoted by the World Bank, UN leaders and number of influential governments, as *the* innovative policy of the New Millennium. International civil servants and UN member states are being encouraged to engage in one way or another in various PPPs. Undoubtedly UN institutions and states can both benefit from interactions and collaboration with the private for-profit sector. But concerns have been raised that an uncritical rush into closer relations with business may erode member states' decision-making powers, undermine the UN system, and give transnational corporations and their trade associations additional channels by which they can exert undue influence in public affairs and gain unfair advantage over smaller or Southern-based companies.

Research commissioned by the Ministry of Foreign Affairs of Finland on *Global Health Related Public-Private Partnerships and the United Nations* found that these concerns were inadequately addressed in the political arena. In particular, the existing safeguards were insufficient to protect public interests within UN-business interactions. Managing conflicts of interests seemed to pose particular problems. The research thus advocated "an assessment … of the safeguards in place to ensure UN integrity and [to ensure] that public interests remain at the core of all UN activities" (Ollila 2003: 8). The research project presented in this publication is a direct follow-up of that recommendation.

Aims of the research project

This research project focused on *Public-Private Partnerships and International Health Policy Making: How to Ensure the Centrality of Public Interests?* It had two main aims:

1. To map out the evolution of selected UN safeguards to protect public interests and to assess their adequacy;
2. To explore the theoretical and practical problems in putting effective and adequate conflict of interest procedures into practice.

The purpose of the research was to develop recommendations that Finland and like-minded countries may consider making to UN agencies to facilitate the improvement and strengthening of existing guidelines and procedures to safeguard the UN's integrity and independence in intergovernmental policy-making, norm-setting, and public interest advocacy in the field of health.

Research methodology

The project's tasks included:

- Collecting information on existing and evolving guidelines and procedures at WHO and other relevant UN bodies (in particular, UNICEF and the Global Compact Office);
- Compiling a history of the debates on public-interest safeguards at WHO;
- Examining the major practical and theoretical challenges for establishing appropriate and effective safeguards for public interests in the context of the trend towards global public-private partnerships.

A literature review of key documents on global public-private partnerships and selected UN guidelines for interactions with the private sector was complemented with interviews and discussions with UN officials, academics, and representatives of public interest NGOs, and with observations of relevant discussions within WHO's governing bodies (World Health Assemblies in May 2003 and 2004 and the January 2004 Executive Board Meeting).

The 25 UN officials who were interviewed from October 2003 to June 2004 included technical and programme officers with experience in interacting with the private sector, heads of departments, executive level officials within WHO and UNICEF, and two staff of the Global Compact Office.

The semi-structured interviews lasted from 30 minutes to two hours. The formulation of the questions depended on the position and function of the official being interviewed. Some questions were aimed at gaining a better understanding of which safeguards had been developed and which not, and which ones were in the public domain and which were considered for internal use only. If a key document had not been made public, the interview tried to ascertain the reasons why this was so.

Interviews with technical and programme officers usually centred on two underlying questions:

- What formal and informal safeguards have helped international civil servants to assess whether an envisaged cooperation or funding relationship with a private sector actor would contribute to public interests to the full?
- What mechanisms or arguments have helped UN staff members ward off industry pressure or enabled them not to engage in arrangements and relationships that they perceived as running counter to public interests?

The information obtained was analysed from a public interest perspective by referring to literature in three fields: conflicts of interest in public office, medicine and science; health and human rights; and global democratic governance.

Overview

This publication is divided into six chapters.

The first chapter summarises some definitions of public-private partnerships that are currently employed in UN circles. It outlines some common assumptions underlying the public-private partnership policy model, and draws attention to the various levels at which the issues can be analysed.

The second chapter discusses the evolution of public interest safeguards within the World Health Organization to guide officials in their interactions with the private, for-profit sector. The Organization's work on developing safeguards has not been completed even though WHO's leadership has vigorously promoted the public-private partnership paradigm since 1998 and despite requests from WHO's member states that WHO establish safeguards and share with them knowledge about the ethical management of interactions with commercial actors.

Historical examination of WHO's development of public interest safeguards indicates that progress has become stalled for political reasons as much as theoretical or technical ones. Chapter Two indicates ways in which conflict of interest theory may prompt development to start up again and progress. At the same time, it argues that some of the challenges posed by public-private interactions are not easily captured or dealt with by guidelines and policies. Consequently, adequate ways of addressing these challenges need to be sought at other levels.

This chapter on safeguards within WHO makes the observation that developing an appropriate strategy to safeguard public interests requires attention to be paid not just to conflict of interest theory, but also – and above all – to the understanding that conflict of interest policies have evolved as part of intricate systems of *checks and balances* in democracies, medicine and the sciences. Their development and effective implementation within WHO should not be seen as a bothersome task, but rather as a key prerequisite to a well functioning public institution.

The chapter argues that building up safeguards at a time when UN agencies in general are moving towards closer interactions with business actors needs more than formal guidelines and processes. It requires a clear recognition that the key issue is to recover, maintain and strengthen institutional and societal environments that encourage internal and external checks and balances to ensure that the UN agencies' greater proximity to money and power does not lead to consequences that are harmful to international public interests.

Finally, this chapter highlights an important component of a broader system of checks and balances: citizen action groups (also known as public interest NGOs) that function as watchdog groups and thus exercise some counter-veiling power to transnational corporations. It describes how the promise of the former WHO Director-

General, Dr. Gro Harlem Brundtland, to increase civil society input in the global health arena has resulted in a draft WHO's policy governing the agency's official relations with NGOs that may facilitate further undue business influence in WHO decision-making processes.

The chapter describes how the debates on this proposed *Policy for Relations between the World Health Organization and Nongovernmental Organizations* led to a draft resolution proposing an external, independent review of WHO's mechanisms to safeguard public interests. But given the controversies surrounding both the new policy and the related resolution, member states assembled at the 2004 World Health Assembly adopted neither.

Irrespective of this pending resolution, WHO already has a clear mandate to review and update its safeguards for public interests. The main question, therefore, is how to prevent the current political climate and pressures from weakening rather than strengthening these mechanisms during any formal review of the Policy.

Chapter Three raises an additional aspect of the task of developing public interest safeguards. A few examples of UN partnerships and UNICEF alliances with the private, for-profit sector, illustrate that even the best possible safeguards within WHO could not guarantee the centrality of public interests in the international health arena. Any review of safeguards for public interests in international health decision-making must also encompass a review of the guidelines and mechanisms of other relevant UN agencies, programmes, funds, collaborative centres. It must also address some of the political questions concerning the legally independent global health alliances and the high-level Global Compact initiative.

The fourth chapter describes the context, particularly the push and pull factors and shifts in frameworks of thought that brought forth the public-private partnership paradigm. This illustrates the political sensitivities and challenges tied up with establishing safeguards that are unambiguously based on WHO's constitutional mandate.

Chapter Five outlines some tasks for WHO's Secretariat if it is to finalise its interrupted work of establishing effective and comprehensive safeguards for WHO-business interactions and assisting member states to avoid or manage conflicts of interests appropriately.

In conclusion, Chapter Six makes some recommendations that policy makers in Finland and like-minded countries may wish to adopt in pursuing the goal of updating and strengthening safeguards at the international health policy level.

1. What are public-private partnerships?

Literature and debates on public-private partnerships (PPPs) remain confusing for three main reasons. First, even though public-private partnerships have been promoted by the World Bank, the UN, a number of influential governments, businesses and think tanks as a positive innovation for several years now, there is no one agreed-upon definition. Second, most discussions do not distinguish between PPPs as a policy model and actual examples of public-private partnerships and interactions that have been undertaken.

And third, PPP is not the only term by which the interactions between the public and the private sector under scrutiny are described. UN, academic and corporate literature that explores PPPs uses terms such as collaboration or alliances with the business sector; public-private joint initiatives; voluntary initiatives; multi-stakeholder initiatives or dialogues; corporate social responsibility- or corporate citizenship initiatives; cause-related marketing; corporate sponsorship; venture philanthropy; and reputation- and issues-management.

Definitions

When the UN consulted its member states in 2001 on their views about the trend towards global partnerships between the United Nations and the commercial sector, one respondent observed that:

> "There is a lack of common definitions on what partnerships mean and involve and in how they differ from or relate to other types of relationship with the private sector." (UN 2001: 16)

A year later, Jane Nelson, in her book *Building Partnerships* that had been commissioned by the UN Global Compact Office, an office responsible for coordinating one of the highest-profile UN-business partnerships (see page 65 ff; 74 ff), remarked, "there has been a tendency, within the United Nations system and elsewhere, to use the concept of partnership very loosely to refer to almost any kind of relationship." She suggested the following definition:

> "Partnership is a voluntary and collaborative agreement between one or more parts of the United Nations system and non-State actors, in which all participants agree to work together to achieve a common purpose or undertake a specific task and to

> share risks, responsibilities, resources, competencies and benefits." (both quotes, Nelson 2002)

A slight variation of this definition made it into the latest Report from the UN Secretary-General on *Enhanced Cooperation between the United Nations and All Relevant Partners, in Particular the Private Sector*. The Report, published in August 2003, focuses on arrangements in which the United Nations has an interest, either as a partner or as a partnership promoter.

> "Partnerships are commonly defined as voluntary and collaborative *relationships* between various parties, both State and non-State, in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks, responsibilities, resources, competencies and benefits." (UN 2003b: 4, emphasis added)

In the health arena, the most-commonly used definition is that proposed by academics Kent Buse and Gill Walt from the London School of Hygiene and Tropical Medicine. They define a *global public-private partnership for health* (GPPPH) as:

> "a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour." (Buse and Walt 2000: 550)

Why did Buse and Walt define a 'public-private partnership' as an arrangement between three parties rather than just two? Because their research focuses on a particular type of global arrangement that often includes additional parties such as civil society groups, governments and donor agencies (Buse and Walt 2002: 44).[1] [2] They also often involve the creation of an intermediary body to channel funds and/or to govern the arrangement.

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[1] For more details, *see* Buse and Walt 2002: 44. For different classifications of PPPs in the health field, *see also* Zammit 2003: 240.

[2] Another definition is that by Roy Widdus, coordinator of the the Global Forum for Health Research's Initiative on Public-Private Partnerships for Health. He defines public-private partnerships for health as "arrangements that innovatively combine different skills and resources from institutions in the public and private sectors to address persistent global health problems." www.ippph.org, accessed 16 June 2004.

What's new about public-private partnerships?

Two kinds of statement are often made by PPP advocates about the novelty of global public-private partnerships. One presents and promotes partnerships with business as a path-breaking innovation. The other, often made in response to criticisms of PPPs, maintains that they are not fundamentally new and points to a long history of UN-business interactions.[3]

Despite their apparent contradiction, both statements have some truth to them. The majority of public-private partnerships are not, in fact, fundamentally novel. In the field of health, for example, they include interactions between the public and private sector such as:

- fundraising – requesting, accepting or channelling corporate donations in cash or in kind;
- negotiations or public tenders for lower product prices (for example, of pharmaceuticals and vaccines);
- research collaborations;
- negotiations, consultations and discussions with corporations and their business associations about public health matters (for instance, salt manufacturers iodizing salt);
- co-regulatory arrangements to agree and implement 'voluntary' (that is, legally non-binding) codes of conduct;
- corporate social responsibility projects (many of which are, in fact, cause-related marketing- or other strategic sponsorship projects); and
- contracting out of public services, such as water supplies.

Subsuming such widely different issues as fundraising from transnational corporations and privatizing water supplies under the common label of public-private partnerships causes several problems. It obscures important distinctions between different types of interactions and conveys a false impression about the novelty of the PPP approach.

But some newer types of public-private interactions have emerged since the PPP paradigm was launched in the 1990s. Some analysts have suggested that these should be viewed as 'social experiments' (Buse and Waxman 2001). They include global health

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[3] The 2000 *UN Guidelines on Cooperation between the United Nations and the Business Community*, for instance, open with the statement: "The business community has played an active role in the United Nations since its inception in 1945. A number of UN organizations have a successful history of co-operating with business. Recent political and economic changes have fostered and intensified the search for collaborative arrangements."

alliances such as the Global Alliance for Vaccines and Immunizations (GAVI), the Global Alliance for Improved Nutrition (GAIN) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). They also include high-level policy interactions between the UN and corporations, such as the Global Compact and business roundtables.

The major novelty of public-private partnerships is the framework of thought underlying the approach. As Jane Nelson suggests, a key feature distinguishing partnerships from other interactions with the private for-profit sector is what she calls the "*shared process of decision making.*" This is the critical novel characteristic of the new policy paradigm. According to Nelson:

> "In the most strategic partnerships, the partners will work together at all levels and stages, from the design and governance of the initiative, to implementation and evaluation." (Nelson 2002: 47)

Indeed, the notion of shared decision-making between public and private business actors is the single most unifying feature of public-private 'partnerships.'[4]

Researcher Ann Zammit, who made an extensive review of UN-business partnerships for the United Nations Research Institute for Social Development (UNRISD) and the South Centre, remarks:

> "The term [partnership] covers a multitude of activities and relationships, perhaps best conceptualised as a special case of 'close' rather than 'arms-length' relationships between government and business." (Zammit 2003: xxv)

Levels of analysis and discussion

This publication does not discuss the pros and cons of the various definitions of public private partnerships. (Some other key assumptions underlying the PPP paradigm are discussed in Chapter 2.)

It is essential to be aware, however, that three levels of analysis and discussion about PPPs are often blurred because the term 'public-private partnership' is used to describe:

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[4] This is why Ollila suggests using 'public-private *interaction* (PPI)' as a general term to describe an interaction between the UN and for-profit entities, and 'public-private *partnership* (PPP)' for those interactions that include for-profit entities in public policy-making and setting public agendas and priorities (Ollila 2003b: 2).

- a policy paradigm (including the underlying framework of thought/ideology);[5]
- various categories of public-private partnerships or interactions (PPPs/PPIs), such as donations of pharmaceuticals;
- specific public-private partnerships or interactions, such as the Malarone® [malaria drug] Donation Programme.[6]

It is thus critical to make a theoretical distinction between these three uses of the term 'public-private partnership', so as to avoid the confusion that is so prevalent in debates on the topic. For instance, institutions often respond to critical questions about the partnership-with-business paradigm with examples of one or two specific public-private collaborative projects that they believe have proved successful.

The term 'public-private interactions (PPIs)' is used throughout this study as an overarching term to describe interactions between the public and the private sector. The decision to opt for this more encompassing and less value-laden term was made because a study on safeguards for interactions between intergovernmental public institutions and commercial and business interest actors needs to focus not just on those interactions in which UN agencies choose to engage under the banner of partnership, but also on those interactions and joint initiatives that UN agencies may feel pressured to engage in.

What is the private sector?

When the UN started promoting the public-private partnership paradigm in the late 1990s, it had no clear definition of 'private sector.' The Report of the Secretary-General to the General Assembly 2001 on *Cooperation between the United Nations and all relevant partners, in particular the private sector* defined the private sector as "all individual, for-profit, commercial enterprises or businesses, business associations and coalitions and corporate philanthropic foundations" (UN 2001:45-46).

Its more detailed explanations specifically excluded 'family foundations', such as those established by media magnate Ted Turner or Microsoft founder Bill Gates, from the category of corporate philanthropic foundations on the grounds that these

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[5] In principle, given the unequal relationship between public sector actors and private sector actors (often transnational corporations and their trade and issue-related lobby associations) and given their fundamentally different roles and fiduciary obligations, the term 'partnership' in 'public-private partnerships' should always be put into quotation marks. But for ease of readability, this has been done in only a few key instances in this publication.

[6] For a selected list of global PPPs for health, *see,* for instance, Buse and Walt 2000a: 701–3.

foundations have clearly stated "not-for-profit, public-purpose values and policies" (UN 2001:46). It can be argued, however, that both these foundations should be included in the private sector category when discussing public-private interactions, particularly corporate sponsorship. First, because donations from Ted Turner's United Nations Foundation and the Bill and Melinda Gates Foundation are quoted in all UN documents as a visible symbol of the supposed success of the public-private partnership policy paradigm in mobilising previously untapped resources. Second, because both foundations are based on a Californian style venture philanthropy model that has an underlying business philosophy and aims to channel business thinking and operating styles into the projects it funds. Third, in contrast to the Ford or Rockefeller foundations, the founders of both these foundations are still active executives of companies operating in highly competitive business areas. UN agencies will therefore have to scrutinize carefully whether donations from these foundations might give their associated corporations undue advantages in terms of profit or reputation enhancement.

2. The development of safeguards within the World Health Organization (WHO)

Each UN agency has its own history of when and how it embarked on partnerships with the private for-profit sector, and when and how it tackled the development of guidelines and other mechanisms to circumscribe their relationships with this sector.

This study concentrates on the development of public interest safeguards within WHO, but also highlights some of the factors that stimulated and influenced the policy trend within the UN system. There are two reasons for focusing on the World Health Organization. First, safeguards at WHO are important as it is the world's highest authority in international public health matters. Second, WHO has probably done more thinking that many other UN agencies on the safeguards it needs while increasing the volume of its interactions with business interest actors. It was also one of the first UN agencies to issue guidelines on interactions with the commercial sector that took the partnership paradigm into account.

The histories of the development of public interest safeguards within the different agencies are drawn from several sources, particularly key academic, WHO and UN publications on global public-private partnerships and interviews with UN staff members who were actively involved in developing the policy paradigm and/or safeguards. These histories are inevitably patchy. Interviews made it clear that each staff member has a different experience and recollection. Moreover, staff turnover leads to a continual loss of institutional memory. It was not always possible to interview staff members who had been key protagonists or witnesses of the beginning of the PPP trend. Some interviewees gave divergent accounts that I was not always able to resolve.

Despite these methodological challenges, this study managed to trace the most significant cornerstones in the development of public interest safeguards within WHO headquarters so as to draw out essential policy questions.

In the beginning

Like many other UN agencies, WHO has interacted with the business sector for a long time. But when did its trajectory towards public-private partnerships start? Did the Organization upgrade and complement its existing safeguards in step with the changing needs that this policy shift brought about?

Academics Buse and Waxman date the beginning of the PPP trend within the World Health Organization to 1993 when the "World Health Assembly called on

WHO to mobilize and encourage the support of all partners in health development, including nongovernmental organizations and institutions in the private sector, in the implementation of national strategies for health for all" (Buse and Waxman 2001:748). In fact, the relevant WHA Resolution 49.17 did not urge WHO's Secretariat to follow this path, but rather developing countries.

The Assembly's 1993 *Call for Collective Action* was not asking for more partnership-interactions with business at global level. It was primarily a call to step-up implementation of the *Global Strategy for Health for All by the Year 2000*, which had been WHO's guiding strategy since 1978 when the Organization, together with UNICEF, had advanced the Alma Ata Declaration on primary health care. The *Call for Collective Action* placed particular emphasis on the importance of strengthening technical cooperation among developing countries (TCDC).

The Resolution also asked the WHO Director-General to "strengthen international technical cooperation for reinforcing and reorienting WHO programmes to mobilize effectively political, technical and financial support for the achievement of health goals." It asked WHO's richer member states to make this possible by facilitating transfer of technology and resources to developing countries and by providing WHO with the necessary financial resources for its work. The original Health for All framework assigned nation states the task of determining what role business should play when the states implemented the policy. The one sentence in the 1993 Resolution that uses the word 'partners' cannot be interpreted as a call for fundamental shift towards 'partnerships' with the private sector.[7]

Three years later in 1996, a WHO internal Working Group on Partnerships examined the promotion of 'partnerships for health' as part of overall WHO reflections on how to renew the Health for All Strategy for the 21st Century. A report from this working group contained the first suggestions of principles that should govern WHO's interactions with the corporate sector and with NGOs (WHO 1997). These suggestions became more publicly accessible two years later by means of an article published in a statistical journal. The authors were the chair of the Internal Working Group, Ilona Kickbusch, and a member of the Working Group, Jonathan Quick, who was also Director of WHO's Action Programme of Essential Drugs (Kickbusch and Quick 1998).

The key event in WHO's development of safeguards, however, was undoubtedly the election in 1998 of the Norwegian ex-premier, Gro Harlem Brundtland, as the WHO Director-General. In her inaugural speech to the World Health Assembly, Dr.

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[7] For more details, *see* WHO 1993.

Brundtland announced a firm commitment to stronger relationships with business as part of the Secretariat's new outreach policy:

> "The private sector has an important role to play both in technology development and the provision of services. We need open and constructive relations with the private sector and industry, knowing where our roles differ and where they may complement each other. I invite industry to join in a dialogue on the key issues facing us." (Brundtland 1998)

On her first day in office in July 1998, Dr Brundtland enacted new *Standards of Conduct and Financial Disclosure* for high-level WHO officials (*see* Annex 1). The aim was to "send a clear message of high standards from the outset" of her administration (WHO 1998). But ever since, WHO's public policy discussions and its development of safeguards have lagged behind the partnership trend becoming institutionalised within the Organization.

Apart from the *Staff Regulations of the World Health Organization* (2002) and the *Standards of Conduct for the International Civil Service of the United Nations Civil Service Commission* (2002),[8] WHO's current safeguards comprise three elements:

- *Guidelines on Interaction with Commercial Enterprises to Achieve Health Outcomes;*
- A corporate assessment procedure;
- Conflict of interest guidance.

Each safeguard is at a different stage of development. A coherent, comprehensive policy framework that is transparent for outsiders has yet to emerge. The main reason that these safeguards are incomplete – and some of them not easily available – seems to stem from WHO's reluctance at the highest level to see a candid and potentially controversial debate emerge on the adequacy of the agency's public interest safeguards.

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[8] According to my interviews, the specific principles for financial disclosure for high-level officials mentioned in the WHO 1998 press-release "Director-General Implements New Code of Conduct on Financial Disclosure" were not specifically included in the staff rules. But they are being put into practice by WHO's Legal Office, which demands annual statements on financial interests from the top three hierarchical layers of WHO officials.

Guidelines on Interaction with Commercial Enterprises

WHO was initially relatively open about its elaboration of safeguards. A preliminary version of the *WHO Guidelines on Interaction with Commercial Enterprises* was made available to WHO staff and member states for comment during the summer of 1999 and to some public interest NGOs in the autumn of that year. The Chair of the Committee of the Private Sector Division expressed the hope that these Guidelines would "contribute to … public confidence in our dealings with the private sector while enabling innovative and positive approaches to our cooperation and partnership" (WHO 1999b).

Several NGO respondents pointed out that the process should not just be about providing comments on the Guidelines. They emphasized that WHO should not interpret their doing so as implicitly endorsing or legitimizing WHO's partnership approach with business. They urged WHO to open up the guideline debate as part of a broader discussion on the whole concept of UN 'partnerships' with commercial enterprises (for example, IBFAN 1999, HAI 1999).[9]

This did not happen. In January 2001, a version of the *Guidelines on Interaction with Commercial Enterprises to Achieve Health Outcomes* (as revised in November 2000) was presented as a document "to note" at WHO's Executive Board meeting. Many countries voiced their grave concerns about the inadequacy of the Guidelines and the need for a broader debate (WHO 2000c).

At this Board Meeting, some of the attending public interest NGOs[10] drew the delegates' attention to a WHO co-sponsored seminar, the International Seminar on Global Public-Private Partnerships for Health and Equity, held two months previously. This seminar had categorically concluded that WHO should "step back from the current situation and reflect upon the appropriate role of GPPPs [Global Public Private Partnerships] in order to meet public health and equity needs."[11]

They also informed Board Members that the seminar had, in addition, recommended that WHO hold public discussions involving governments and civil society organizations, particularly those from developing countries (CI/HAI/IBFAN 2001).

The Executive Board resolved to hold an electronic discussion on the *Guidelines for Interaction with Commercial Enterprises* and their further elaboration. Yet shortly afterwards, WHO's Director-General decided that formal approval of the Guidelines by the member states was not needed. She adopted the revised November 2000 Guidelines as a 'managerial tool' for WHO without change. The electronic debate was

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[9] For a summary of other concerns, *see for instance* Beigbeder 2004: 31.

[10] WHO Executive Board Meetings and the World Health Assembly are open to the public (upon registration). NGOs in official relations with WHO can deliver statements at these meetings.

[11] Reference is made to SID/WHO/ISS 2000.

transformed into discussions during the Executive Board retreat later that year in November 2001. Deliberations of these retreats are usually not published.[12]

In a note on WHO's involvement in public-private interactions for health presented at the Executive Board meeting in January 2002, however, the Director-General gave a brief summary description of the discussions during the November 2001 retreat. This note is not equivalent to minutes of discussion, but does give some indication of the main concerns voiced by the Executive Board members at the retreat.

The note suggests that they expressed interest not only in reviewing WHO's experiences with public-private partnerships in health,[13] but also in the Organization's "experiences of rejecting inappropriate suggestions for interactions." Furthermore they:

> "noted that there can be risks of, for example, focusing on the production of inappropriate medicines, equipment or commodities. There is a need to ensure that health systems are not distorted by donations; that costs remain under control; and that advice is independent. There is a potential for real or perceived conflicts of interest. Staff need to be trained to avoid these and a system of checks and balances needs to be in place."

They also requested the Secretariat to share with them the measures that WHO had taken "to manage public-private interactions and avoid conflicts of interests." Their expressed expectation was that they could draw on such measures in their own interactions with the private sector (WHO 2001).

The Director-General's note listed seven measures that were in place or envisaged to manage public-private interactions and avoid conflicts of interest (*see* Box 1). (As of mid-2004, several of them are still not in place.) But doubts continued to be expressed about the adequacy of these measures and their implementation.[14]

For example, Dr. Brundtland promised that the *Guidelines for Interaction with Commercial Enterprises* would be updated regularly to reflect WHO's ongoing experience. Yet they have not been revised since 2000 even though questions have been asked, for example, about the appropriateness of WHO's accepting staff on temporary secondment from commercial actors and about the adequacy of the overall decision-making framework in relation to global health alliances that are legally independent of WHO.

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[12] For more information, *see* Ollila 2003c: 41–42, 54–55.

[13] The Annex to the Director-General's Note *WHO's Interactions with the Private Sector: Some experiences* listed some of these experiences.

[14] For example, Buse and Waxman 2001; Buse and Walt 2002; Ollila 2003b; Richter 2003b; Buse 2004; Beigbeder 2004.

Box 1:

WHO's existing or envisaged measures to manage public-private interactions and conflicts of interest as of December 2001

- proposals for any interaction between WHO and the private sector will need to be accompanied by a clear statement of purpose;

- guidelines to staff on handling interactions [*the Guidelines for Interactions with Commercial Enterprises*] will be updated regularly to reflect experience and will include text on recognizing and avoiding conflict of interest. Although the guidelines are primarily for Secretariat use, they will continue to be available on the WHO headquarters web site for the information of Member states and the public;

- staff training modules on issues relating to private-sector interaction and conflict of interest are being developed;

- declaration of interest forms are in use for all senior staff and WHO experts participating in meetings. These forms require declaration of any interest which may relate to the topic of the meeting or to the work of staff;

- a civil society initiative is in place to ensure input and engagement from nongovernmental organizations. This will also facilitate the input of the organizations' views on issues pertaining to public-private interactions;

- work is progressing on a tool to help assess the good standing and practices of any companies with whom interaction is envisaged;

- private sector interactions will be documented and reported to the Executive Board and Health Assembly, and will be available to the public.

Source: WHO (2001), Public-private interactions for health: WHO's involvement. Note by the Director-General. Doc. EB109/4. 5 December

Corporate assessment procedure

Two other safeguard elements at WHO are less well known to its member states and the broader public: a corporate assessment procedure, and staff guidance and training on conflicts of interests. How did these safeguards evolve? At what stage of development are they?

Criteria for WHO's selection and assessment of potential corporate 'partners' were first outlined in 1997 by the WHO Internal Working Group on Partnerships and publicized in a slightly revised form by Working Group members Kickbusch and Quick.[15] Work to develop an institutional corporate assessment tool gained momentum after Dr. Brundtland became Director-General in 1998.

The 1999 preliminary *Guidelines on Interaction with Commercial Enterprises* contained some guidance, albeit scattered throughout the document, on how WHO might assess the suitability of a commercial enterprise or industry sector. It also gave advice on how to assess specific interactions with a particular commercial enterprise or industry sector. The document stressed the importance of avoiding conflicts of interest, advised WHO departments to avoid any association with companies whose past activities "might reflect poorly on the credibility of WHO," and emphasized the need to ensure that a commercial enterprise is a "suitable partner for WHO"[16] (WHO 1999c).

Following discussions about the implicit discourse in the preliminary 1999 Guidelines, the revised 2000 *Guidelines on Interaction with Commercial Enterprises to Achieve Health Outcomes* use the more neutral terms of 'commercial enterprises' and 'contributor' rather than 'partner'. They advise a "step by step evaluation of the commercial enterprise, including an assessment of the company and consultation with the Office of the Legal Council" as the "best way of identifying potential areas of conflict of interest." The Guidelines specifically advise WHO departments to avoid relationships with commercial enterprises "whose activities are incompatible with WHO's work, such as the tobacco or arms industries."

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[15] Cf. points : (I) WHO policy toward the industry involved; (II) suitability of the individual company (Kickbusch and Quick 1998:72). Some of their suggestions were taken up by WHO's Resource Mobilization Unit, when developing a first corporate assessment tool (unpublished document 2000).

[16] The preliminary Guidelines suggested that departments should ask themselves the following questions when developing a policy towards a specific industry:

- "Are the major products and services of the industry beneficial to health?"
- "Does the industry engage on large scale in practices which are negative to health?"
- "Does the likely public health benefit outweigh any possible harmful practices, products or services", p.3.

To assess the suitability of a specific company, the Guidelines refer to evaluation criteria that are "similar to those already in use of public agencies in assessing potential partnerships with enterprises, including the public image, financial stability and integrity of the company." Moreover "commercial enterprises working with WHO will be expected to conform to WHO public health policies in the areas of food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control and others" (WHO 2000b, paras 9, 11, 12).

The Guidelines also provide suggestions for assessing how suitable a specific interaction with a proposed sponsor is. For instance, they prohibit WHO from seeking funds from enterprises "that have a direct commercial interest in the outcome of the project toward which they would be contributing" (with the exception of clinical trials) and advise departments to exercise caution in accepting funding from commercial enterprises "that have even an indirect interest in the outcome of the project" (WHO 2000b, para 15 & 16).

In their 2001 assessment of WHO's existing safeguards, Buse and Waxman expressed the opinion that WHO did not have the internal capacity nor expertise to screen companies "in a credible manner." They recommended that WHO contract this task out to a third party, such as a professional audit service, a civil society organization, or a specially mandated UN body (Buse and Waxman 2001).[17]

By the time Buse and Waxman's article was published in 2001, the process was already underway. WHO's Secretariat seems to have decided not to lobby for a specially mandated UN body to make corporations more transparent to UN member states and the general public. Instead, in 2002, WHO and four other international organizations – the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the Office of the UN Secretary-General (UNOSG) and the World Bank – contracted the services of an ethical investment company, Calvert, to assist them.[18]

The aim of this arrangement was to ensure that the international organizations would become better informed about the background of commercial actors before engaging in fundraising, negotiations or collaborative projects with them. Calvert's social responsibility research unit establishes company profiles by screening information against a set of common criteria.

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[17] For previous suggestions on how to improve of the corporate assessment process and criteria, *see* Annex 2 and Waxmann 2000: 11.

[18] The President and CEO of the social investment fund Calvert, Barbara Krumsiek, is on the Advisory Board of the Global Compact.

These criteria had been developed by the five agencies in cooperation with the UN Fund for International Partnerships (UNFIP). Half the 'social responsibility criteria' – benchmarks from the fields of human rights, environmental conduct, and labour rights – are modelled along the lines of the Global Compact. The remaining areas are health, social responsibility (in practice, corporate sponsorship activities) and ethical information (including company involvement in alcohol, tobacco, arms and gambling, company ethics and anti-corruption policies, and their research and development (R&D) practices) (for more information, *see* Annex 2).

Calvert gives each company a rating based on these criteria. Calvert's information on the companies is considered confidential; its databank is accessible only to individuals in the five contracting agencies.

WHO officials usually complement this information by carrying out more detailed research on the specific circumstances of the proposed joint project and assessing whether the enterprise has any potential hidden agendas. WHO then takes a decision on whether or not to engage in a sponsorship relationship or other interaction with that company. The quality of this assessment depends critically on the skills and values of the WHO officials involved in the process.

Conflict of interest guidance

A section of the 1999 preliminary WHO *Guidelines for Interaction with Commercial Enterprises*, entitled "Principles of Collaboration", outlined the link between the Guidelines and conflicts of interest:

> "Conflict of interest is of particular concern for WHO's work in developing public health guidance, in setting regulatory standards and in other activities which may affect product costs, market demand, or profitability of specific goods and services. Such activities included norms for quality, safety, efficacy, promotion practices, and information provision for pharmaceuticals; diagnostic and treatment guidelines or advice which may affect the market for individual products and product categories; chemical safety standards; and nutritional guidelines."

> "To avoid conflict of interest, real or perceived: (i) the concerned WHO Offices and Departments must establish procedures which ensure that the establishment of norms and standards is based on science and evidence and not on commercial interests; and (ii) any interaction with commercial enterprises must be audited and monitored."

A footnote mentioned:

> "It is anticipated … to expand … the section [on Principles to Collaboration] to deal in more detail with ethical issues arising in the establishment of collaborative arrangements with commercial enterprises." (WHO 1999c)

But when the WHO Director-General adopted the November 2000 *Guidelines on Interaction with Commercial Enterprises to Achieve Health Outcomes* as a managerial tool, the "Principles" had not been expanded upon. Instead they had been replaced with a "General Considerations" section, which stated that:

> "In developing relationships with commercial enterprises, WHO's reputation and values must be ensured. Scientific validity must not be compromised. Staff should always consider whether a proposed relationship might involve a real or perceived conflict of interest, either for the staff member or for the work of the Organization. The Staff Rules and Staff Regulations (and the *forthcoming ethical framework*) should guide decisions on conflict of interest relating to the personal situation of staff. The present guidelines contain provisions relating to conflict of interest for the Organization." (WHO 2000b, emphasis added)

The current Guidelines contain many advices on how to assess specific interactions with commercial actors (which are classified under: donations in cash and kind, staff secondment, collaboration on product development, cost-recovery for WHO evaluations, rules for meetings, 'multi-party alliances' and product pricing arrangements).

But nearly four years later, no comprehensive ethical framework to guide WHO's relationships with the commercial sector has been produced. The evolution of WHO's conflict of interest guidance indicates that existing conflict of interest documents have been developed piecemeal in response either to revelations about the efforts of corporations to exercise undue influence in international public health matters and/or to concerns expressed about WHO's failure to protect the integrity of public health decision-making sufficiently. The existing documents do not seem to be the result of a systematic, concerted strategy within the Organization to build up a coherent system of safeguards for public-private interactions.

Declaration of Interests for WHO Experts

The Declaration of Interests for WHO Experts, for instance, issued by the WHO Secretariat in 2000, seems to have been developed primarily in reaction to, first, complaints about the way WHO and its collaborating centres were handling industry participation in their expert committees, and, second, as a side product of WHO's efforts connected to the proposed Framework Convention on Tobacco Control.

Pressure began soon after Gro Harlem Brundtland became WHO Director-General. In December 1998, the Center for Science in the Public Interest (CSPI), together with a number of scientists, drew Dr. Brundtland's attention to problems with safeguards and procedures at one of WHO's collaborating centres, the International Agency for Research on Cancer (IARC). They had documented that half the experts on a review committee looking at the carcinogenicity of saccharin had been affiliated with food or chemical companies or were known for their opinion that saccharin does not cause or promote cancer. The Center and the scientists claimed that the process had been so unscientific and industry-biased that the review appeared "rigged to exonerate saccharin."[19]

CSPI's website documents a more than four-year debate via correspondence and media articles demanding that WHO improve IARC's conflict of interest safeguards to prevent industry gaining undue influence on the grading of chemicals and foodstuffs according to their cancer-causing effect.[20]

Also in December 1998, health professionals and public interest NGOs expressed concerns about the way in which WHO had allowed a drug manufacturer to influence new guidelines on managing high blood pressure that had been issued jointly by the WHO and the International Society of Hypertension. A few months later in March 1999, more than 400 doctors, pharmacists and scientists from 42 countries signed a letter to Dr. Brundtland raising the same concerns. They claimed that the new guidelines, and the way in which the drug manufacturer exploited them, would result in "increased use of anti-hypertensive drugs at great expense and for little benefit" (Woodman 1999).[21] [22]

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[19] To correct the bias, they suggested that WHO should demand that IARC withdraw the report and re-evaluate saccharin's cancer-causing potential in a new process under a new IARC director supervising the evaluation of chemicals.

[20] For more details and weblinks to the relevant correspondence and supporting documents, *see* the website of the Center for Science in the Public Interest (CSPI) on its project: WHO/International Agency for Research on Cancer, www.cspinet.org/integrity/iarc

[21] For the original letter and answer of Dr. Brundtland, *see* www.uib.no/ifs/letter and www.uib.no/ifs/letter/reply (accessed 6 April 2004). These signatures subsequently increased in number to nearly 900

At the World Health Assembly in May 1999, an ad-hoc coalition of public interest organisations and networks raised yet more questions. This time they focused on WHO's allowing pharmaceutical companies to gain greater influence in its decision-making processes. Besides the hypertension management guidelines, the NGO coalition highlighted the inappropriateness of the secondment of a Merck, Sharp and Dohme (MSD) employee to WHO's Tobacco Free Initiative. An internal announcement within this pharmaceutical company called the secondment a "pioneering arrangement" and expressed the hope that the employee could act as an "effective ambassador" within WHO. The NGO coalition asked the Director-General to explain how the Organization would avoid conflicts of interest when accepting funding from and working in close partnership with the private sector. They requested that the Director-General exclude 'staff secondments' from the range of collaborative arrangements envisaged between WHO and industry (HAI et al. 1999).[23]

Dr. Brundtland replied in June 1999 that she did not "wish to rule out the possibility of secondments to WHO from pharmaceutical companies." She wrote:

> "In the case of the secondment to the Tobacco Free Initiative, the company had no interest in the area of smoking cessation, the person seconded brings to the project a specific and needed expertise for a time limited period, and the person is specifically excluded from involvement in activities in which the company from which she is on secondment could have any interest. Finally, there are clear undertakings on confidentiality, and on the person involved not seeking or accepting instructions from anyone outside WHO, specifically the company from which she is on secondment." (quoted in Beigbeder 2004: 35)

Her answer failed to address two issues. First, that any person who is employed and paid by a particular company yet working for a public institution is exposed to a

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from 58 nations. As a result of these criticisms, the *Guidelines for the Management of Hypertension* were revised.

[22] The independent drug review bulletin, *Revue Prescrire*, had raised the same concerns. In December 1999, it publicized its decision to stop the process of becoming a WHO collaborating centre because of what it considered to be the unsatisfactory response of WHO to its concerns (Prescire International 1999).

[23] Health Action International (HAI) also publicised the proposal of the November 1999 WHO Expert Committee on the Use of Essential Drugs to add nicotine patches to WHO's Essential Drugs List. For more details on HAI's concerns and suggestions for addressing the problems at the time, *see also* HAI 2000 and Hayes 2001. For HAI's arguments against an earlier staff secondment by the pharmaceutical industry to the World Bank, *see* Beigbeder 2004: 35.

fundamental conflict of interest. She has a divided loyalty between the for-profit employer and the public institution. Second, to my knowledge, the work of the Merck, Sharp and Dohme employee was not as carefully circumscribed as Dr. Brundtland's statement suggests. For example, she was listed as WHO staff on the list of persons who were asked to comment on the 1999 preliminary *Guidelines on Interaction with the Commercial Enterprises*.[24] [25]

The most significant catalyst in this whole series of calls to tighten the rules for outside experts on WHO committees was probably WHO's own concern about the aggressive ways in which tobacco giants tried to undermine the agency's regulatory efforts. In summer 1999, an internal report alerted the Director-General to the activities of tobacco companies, which included efforts to reduce funding for tobacco control work within UN organizations (WHO 2000e). WHO appointed a committee of outside experts to conduct a deeper inquiry into the issue. Internal tobacco industry documents that had become public as a result of lawsuits in the US against these companies formed the major basis for this study.

In July 2000, the results of this inquiry were published. The report on *Tobacco Company Strategies to Undermine Tobacco Control Activities at the World Health Organization* (also known the Zeltner report after the chair of the Committee) revealed throughout its 250 pages the ingenuity of the companies in their attempts to "contain, neutralize and reorient" WHO's tobacco control activities.

These activities included: funding academic centres, journalists and consultants to act as 'independent' critics of WHO and to spread pro-tobacco, anti-WHO messages; pitting other UN agencies and tobacco-growing developing countries against WHO; planning to use food subsidiaries of tobacco companies to resist tobacco control efforts; and attempting to influence the results of a study carried out by WHO's collaborating International Agency for Research on Cancer (IARC).

These activities were shocking enough. But the experts also drew attention to the fact that WHO and other UN agencies had themselves contributed to the international policy process becoming so vulnerable to industry influence and its counterstrategies.

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[24] Merck Sharp and Dohme employee Sissel Brinchmann was listed as a contributor and classified as staff of the Tobacco Free Initiative (WHO 2000d).

[25] *See also* Beigbeder 2004: 35, who writes: "Whatever the value of WHO's statements, questions remain. As an 'ambassador' from a pharmaceutical industry, could the seconded employee act as loyal WHO staff member, fighting against big tobacco firms during this short period, then returning to her former functions? Why would a pharmaceutical company agree to pay for an employee to work for WHO if it thought it had nothing to gain from the arrangement? If a specific expertise was needed, could it not be obtained without risk by the appointment of an independent expert, free of any commercial interests for a short period?"

They highlighted, in particular, WHO's vague and confusing conflict of interest safeguards, its lack of training programmes, and the apparent absence of clear enforcement mechanisms (WHO 2000e: 233).

The Zeltner report contains 58 recommendations on how to prevent tobacco companies from negatively influencing the political and scientific processes. To protect the integrity of decision-making processes in an appropriate manner, the committee of experts recommended that WHO and its collaborating centres improve their institutional safeguards. They encouraged WHO to "use its leadership position to open a Task Force discussion on the consistency and adequacy of current conflict of interest and ethics policies within other agencies, and to promote consistent implementation and enforcement of effective policies in all UN agencies" (WHO 2000e: 231).[26]

The experts further recommended that WHO promptly release this report to enable policy-makers and the public to recognize more easily the hidden hand of the tobacco industry and to send "a message to WHO employees at all levels that this external threat to WHO's integrity is real and that WHO's conflict-of-interest and other ethical requirements are to be taken seriously" (WHO 2000e: 228-9).

The report was, however, distributed far less widely. Nonetheless, a combination of outside pressure and WHO consideration of the report's findings did lead to several positive changes: the *Declaration of Interest for WHO Experts*; improved staff regulations; and a World Health Assembly Resolution on transparency in tobacco control. This Resolution called on member states to be aware of affiliations between the tobacco industry and members of their own delegations (WHA54.18) (*see* Annex 3). There were also changes in the policy of the International Agency for Research on Cancer (IARC) (Anello 2001: 26).

Training on conflicts of interest

The tobacco issue also gave some impetus to the development of staff training within WHO on conflicts of interest, something that Dr. Brundtland mentioned as being underway in her note to the 2002 Executive Board (WHO 2001: 2).

A further impetus came from some members of WHO's Committee on Private Sector Collaboration (CPSC), who had been troubled to find out that several WHO officials had been trying to enter a collaborative or sponsorship relationship with certain

[26] The report's executive summary and summary recommendations provide a good overview of industry strategies and recommended measures to counter them (WHO, 2000e: 1–18; 228–243).

corporations in a way that clearly involved a conflict of interest according to the most general understanding of the term.[27] [28]

Thus in early 2001, WHO hired a consultant, Dr. Eloy Anello from Nur University in Santa Cruz, Bolivia, to brief WHO staff on conflicts of interest. In March 2001, Dr. Anello interviewed over 30 senior officials in WHO to identify their needs in both avoiding and managing conflicts of interest. Three months later, he delivered his report entitled *Assessing Conflicts of Interest* to WHO (Anello 2001).

The report was made available to WHO staff for a short time only. At the time of researching this study, however, Anello's report is not available either to WHO staff or to the public.

When public interest NGOs asked in January 2003 why WHO had still not trained any staff in issues relating to conflicts of interests, the response was that it was proving difficult to find a definition of conflict of interest that 'suited WHO's purposes.' What did exist, however, was a definition for individuals in the *Declaration of Interests for WHO Experts*. This stated that:

> "*Conflict of interest* means that the expert or his/her partner ('partner' includes a spouse or other person with whom s/he has a similar closer personal relationship), or the administrative unit with which the expert has an employment relationship, has a financial or other interest that could unduly influence the expert's decision with respect to the subject-matter being considered. An *apparent conflict of interest* exists when an interest would not necessarily influence the expert but could result in the expert's objectivity being questioned by others. A *potential conflict of interest* exists with an interest which any reasonable person could be uncertain whether or not should be reported." (WHO 2000a, emphasis added)

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[27] For example, a manager of the WHO Cancer Programme at the IARC had drawn up a *Briefing Document for Heinz*. The section on 'Sponsorship opportunities' promised, in return for sponsorship of the food TNC, "scientific and healthy living endorsement from WHO ('naughty but nice'); removal of trade barriers into difficult markets for Heinz products, e.g. China by riding on the back of WHO health campaigns." The manager described the arrangement as cost-effective for Heinz because it could "increase market share and drive sales in … new territories without criticism of imperialism or capitalism" (Narinesingh, n.d.). Subsequent debate within WHO led to abandoning the IARC-Heinz fundraising project before it was put into action. For further quotes from the document, *see* Beigbeder 2004: 33.

[28] For additional examples of industry influence and conflicts of interest in WHO's interactions with the commercial sector, *see* Beigbeder 2004: 32–36.

The Declaration goes on to outline how WHO interprets and uses the knowledge gained from the declarations of interests made by outside experts (*see* Annex 4).

But managing WHO's interactions with the private sector so that they are in the public interest goes far beyond ensuring the integrity of the decision-making process in the Organization's technical expert committees. The increased volume of global public-private interactions and joint initiatives in the health arena and the novelty of some of these arrangements pose many new challenges to developing an appropriate and comprehensive ethics-based policy framework.

In 2003, momentum revived when two independent legal experts, Dr. Jean-Marc Reymond and Dr. Edgar Philippin, who at the time were lecturing at the University of Lausanne, Switzerland, were commissioned by WHO to develop a training module on conflicts of interest. In June and July 2003, they held two seminars at WHO headquarters in Geneva for WHO Executive and Programme Directors and technical staff whose work included interacting with the private sector. No such seminars was held at WHO's regional offices.

The staff orientation on conflicts of interest was based on a slide show prepared by the two independent legal experts entitled *Collaborating with the Private Sector: The Conflict of Interest Issue*. As of today, no official training manual exists.

By May 2004, however, it had become uncertain as to whether any more staff training on conflicts of interest would be held. Training will depend, in part, on whether Dr. Jong-wook Lee, who replaced Dr. Brundtland as WHO Director-General in July 2003, and his advisers make it a priority or not.

But deeper probing into the disappearance of Anello's report from the public sphere point at some WHO internal stumbling blocks to issuing the promised training manual on conflicts of interests. WHO management will have to address these stumbling blocks if it intends to provide clear and effective institutional guidance and support for WHO civil servants.

Reasons for delay

When Dr. Anello was commissioned by WHO to write a briefing paper on conflicts of interest, WHO envisaged that staff training seminars would follow on from it. Why was this plan not put into practice? Why were his report – and apparently a subsequent training manual – taken out of the public domain? Why was there such a delay between Dr. Brundtland's 2001 promise to develop training materials and the mid-2003 seminars?

Interviewees gave several answers in response to these questions. All related to Dr. Anello's meeting the terms of reference of his consultancy. "Dr. Anello's work was not considered as an acceptable basis for the proposed training" was one explanation.

Another was that Anello had proposed an ethical definition of conflict of interest while WHO's legal office had wanted a legal one. A third answer was that Dr. Anello had been asked only to 'sensitize' staff to conflict of interest issues, not to give any broader advice on the adequacy of WHO's general policies.

Two approaches

It is worthwhile examining these explanations more closely. Is the claim that Dr. Anello did not fulfil his terms of reference sufficient explanation for WHO's discontinuing his work on conflict of interest training for WHO staff? Did Dr. Anello act contrary to his terms of reference by proposing a definition of conflict of interest that was an ethical definition rather than a legal one?

Anello's report describes the purpose of his consultancy as follows:

> "to complement the document titled 'WHO Guidelines on working with the private sector to achieve health outcomes' by providing WHO staff members with a briefing paper on the subject of conflict of interest. It is felt that the level of consciousness and understanding of the issue of conflict of interest needs to be raised among WHO staff members and the sharpening of skill to apply ethical reasoning in identifying and managing conflicts of interest needs to be enhanced. In conjunction with this paper, a briefing seminar will be given to orient staff members on the use of a conflict of interest auditing tool designed to sharpen critical thinking and ethical reasoning skills." (Anello 2001: 6)

The terms of reference thus seem to have specifically requested Anello to hone the *ethical* reasoning abilities of WHO staff. The terms of reference do not seem to have specified that the suggested definition should be a legal one.

The response that Dr. Anello's *Assessing Conflict of Interest* report was an inappropriate basis for the proposed training seems weak for two reasons. First, it seems that once Dr. Anello had delivered the report, he was contracted by WHO for a second consultancy to devise a training manual on the management of conflicts of interest.

The second reason stems from a comparison of Anello's work with that delivered by the two independent legal experts, Reymond and Philippin. Both approaches start from the same premise, namely, that the primary goal of private companies is to make profit and that their specific activities to achieve this goal may – or may not – be compatible with WHO's mandate and specific objectives.

Anello then suggested that WHO's *Guidelines on Interaction with Commercial Enterprises* should be complemented with a two-tiered definition of conflict of interest: an individual definition and an institutional one.

> **An individual (or personal) conflict of interest** "consists of the types of conflict of interest that arise when a WHO staff member, in his/her relations and interactions with a commercial enterprise or other private entity, uses his/her professional position to influence WHO's decisions and activities in ways that could lead directly or indirectly to financial gain and/or other benefits for the staff member or his/her family to the detriment of WHO and its interests."

> **An organizational (or institutional) conflict of interest** "consists of the types of conflict of interest that arise when a WHO staff member or programme through his/her actions creates a situation in which WHO enters into a collaborative interaction with a commercial enterprise or other private entity in a manner that *puts the interests of the outside organization above WHO's public health mission and objectives*, although the staff member as such would not gain any personal benefit." (Anello 2001: 17, emphasis added)

The two legal experts, Reymond and Philippin, did not come up with a definition for institutional conflicts of interest. They decided to deal with potential risks arising from interactions with the commercial sector by distinguishing between 'conflict of interests' involving staff members and 'potential problems' involving the institution.

They defined **personal 'conflict of interest'** as:

> "a situation in which a WHO staff member or representative finds himself [or herself], voluntarily or involuntarily, in a position where personal interests, obligations or past professional positions may influence his [or her] loyalty and independence in the objective exercise official duties." (Reymond and Philippin 2003)

The **potential problems involving the institution** fell into three sub-headings. Risks to:

- the *independence* of WHO (for example, in standard setting);
- the *image* of WHO (for instance, through association with a company that has been criticized for its unethical practices); and
- of *instrumentalizatio*n of WHO (such as WHO being used to whitewash a corporation's tarnished image, or to endorse pharmaceutical products).

The best way to judge the quality and merits of the two approaches suggested by Anello and the two legal consultants might have been to put their materials into the public domain. A debate comparing the two approaches could help sharpen the thinking of officials of WHO and its member states and of other key publics on the complexity of the issues and might yield interesting new insights.

My comparison with the slide series *Collaborating with the Private Sector* developed by the two independent legal experts suggests that Anello's approach is certainly not inferior to their work, but constitutes a different approach that is also relevant to dealing with conflicts of interest.

Unwelcome advice?

Therefore the responses from WHO interviewees about Dr. Annello's work are not sufficient to explain why WHO staff and the public are no longer able to access Anello's work to judge for themselves whether it is relevant to putting in place better public interest safeguards for WHO's interactions with the commercial sector.

I found Anello's *Assessing Conflicts of Interest* report listed as a valuable resource in a 2001 Report from WHO's Civil Society Initiative.[29] When I asked for the document as background literature for this study, staff members within three different WHO departments informed me with regret that they had received instructions indicating that this document was no longer public. I was able to obtain a copy, however, from an individual who felt that its withdrawal conflicted with WHO's duty of transparency as a public institution.

The most plausible explanation for the secrecy surrounding Dr. Anello's documents is that at least one or two high-level WHO officials did not want Anello's broader advice circulated among WHO staff or made available to the public.

What advice did he give in his report? Anello suggested an 'institutional socialization of a code of ethics' complemented by several measures within the WHO to enforce such a code. His approach aimed to sharpen the ability of WHO civil servants to detect, avoid, but, if necessary, manage conflicts of interests. His 29-page report provides detailed suggestions as to how WHO staff might learn to understand the concept of conflict of interest better and to minimise its occurrence. In addition, the report makes ten recommendations on what WHO as an institution could do to protect its public health mandate and core functions more effectively. It also outlines a conflict of interest audit to help WHO staff check the value and potential problems of any interaction with corporations when it is first proposed.[30]

Without wanting to pre-judge the details of his advice, it seems that a broader discussion within WHO about these suggestions might have helped work on an institutional ethics policy to progress.

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29 *See* the Reading list of WHO/CSI 2001: 11.

30 For a more detailed summary, *see* Beigbeder 2004: 36–37.

In the course of my research, I heard several staff express their concerns that WHO's safeguards were inadequate to prevent WHO from engaging in arrangements with the private sector that they believed were of questionable value. Others described how they had found it more difficult to fend off attempts by industry to gain undue business advantages or influence since 'partnering' had been declared a core practice of WHO. Anello highlighted such situations in his report:

> "There is nothing inherently unethical in finding oneself facing a possible conflict of interest. The manner in which an individual manages the perceived conflict of interest will determine whether or not he/she has been ethical in his/her decision making and action. *Some situations of conflict of interest are due to an institution's failure to provide adequate orientation and training to staff members and to the lack of clear formal rules and procedures on how to deal with conflicts of interest.*" (Anello 2001: 4, emphasis added)

> "WHO as institution must accept responsibility for [organizational] types of conflict of interest … by failing to provide adequate orientation and training to staff members to negotiate more effectively with private entities interactions that protect and promote the interests and objectives of WHO. This is where institutional policies related to the management of conflict of interest and ethical abuses enter the picture … If WHO is vulnerable to this category of conflicts of interest because these procedures and tools are not in place then the institution as a whole should be held responsible for its own vulnerability and not just the individual employee." (Anello 2001: 17)[31]

Were some high-level officials uneasy at Dr. Anello pointing to failings in WHO's safeguards? Scrutiny of the explanations given for the slow progress in setting up staff training in conflict of interest, the fact that Dr. Anello's paper is not available to WHO

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[31] Anello concluded with a comment on industry practices such as those pursued by the tobacco industry: "No matter how aggressively and unethically commercial enterprises may seek to infiltrate and influence WHO's decision making processes, it would be to no avail, if WHO as an institution takes the necessary measures to protect its integrity and independence and if WHO staff members are ethical and competent in dealing with the various forms of conflict of interest that may arise in their interactions with commercial enterprises and other private entities. *Ultimately, the best protection against conflict of interest are the WHO staff members themselves working in an organizational environment and culture that inspires commitment to the institution and which does not tolerate situations of conflict of interest and ethical laxity*" (Anello 2001:18, emphasis added).

staff, and Anello's focus on institutional as well as individual responsibility for conflicts of interest all suggest that the primary cause of WHO's reluctance to make further progress in this area is political.

According to Anello, all the WHO senior officials he interviewed perceived conflict of interest as a 'hot' issue, particularly in light of the rapid trend towards partnerships with the private sector. At the same time, his interviews with staff who interacted directly with the private sector suggested that conflict of interest was a 'taboo subject' within the Organisation (Anello 2001: 14; 18).

What can be concluded from these observations? Why had conflict of interest become a 'taboo subject' when the increased volume of interactions with the private sector, the new partnership philosophy and the new arrangements made the overhaul of WHO's institutional safeguards increasingly urgent?

An obstacle to 'flexible' working with industry?

Some influential actors, both within and outside WHO, seem to have regarded the very concept of conflict of interest as an obstacle to new and closer engagements with industry. They simply wished all mention of it to go away.

One of these actors was the Commission on Macroeconomics and Health, set up by Dr. Brundtland in 2000, which presented its recommendations to her at the end of 2001. These recommendations included reorienting WHO's work to provide support for global PPPs such as the Accelerated Access Initiative (AAI), the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to Fight Aids, Tuberculosis and Malaria (GFTAM). (The Commission's report, *Macroeconomics and Health: Investing in Health for Economic Development,* and its chair, economist Jeffrey D. Sachs, continue to have a powerful impact on international public health matters, both in theory and in practice).

The Commission described concerns expressed by the WHO Executive Board and the World Health Assembly about the potential for conflicts of interests to act as 'constraints' upon a "more open way of working". It declared that "Member states should permit the WHO Secretariat to work in more flexible partnerships with other institutions" (CMH 2001: 100).

Nowhere did the Commission's report explore why member states might have been concerned about partnership interactions with powerful economic actors and donors. The Commission itself did not regard it as problematic that many global PPPs for health give powerful business actors decision-making roles in public health matters at both global and national levels. The Commission itself put into practice its encouragement of business being involved in international policy-making when it asked Harvey Bale, the head of the research-based pharmaceutical industry association,

IFPMA, to draw up the Commission's background paper on international patent legislation and access to drug issues.[32]

A few months after the release of the Commission's report, Dr. Brundtland addressed the International Federation of Pharmaceutical Manufacturers' Association (IFPMA) in February 2002. She appealed to industry leaders to understand the need to protect WHO's integrity and to ensure the "highest possible level of ethical principles and transparency." Clear safeguards, she said, would in the long run be beneficial to their joint efforts. At the same time, however, Dr. Brundtland dismissed as "unfounded" the "persistent fears – in particular among civil society organizations – that private sector collaborations are influencing WHO's policy focus and even the principles that underlie our norms and standards" (Brundtland 2002b: 3). Her speech is another example of the tension created between WHO's desire to promote public-private 'partnerships' and demands that the Secretariat establish clear and effective safeguards to protect WHO from undue industry influence.

Misunderstandings

Some of the reticence towards clearer conflict of interest policies seems to be grounded in misunderstandings. For example, a Senior WHO Legal Officer told me that WHO had not been able to find an official definition of conflict of interest because all the definitions were perceived as 'too constraining'. Another high-level official said that it had proven extremely difficult to draw up a definition that was appropriate for WHO as an intergovernmental agency.

But are all conflict of interest definitions really too constraining for WHO as an intergovernmental organization? Does the constraint not emanate instead from a widespread misunderstanding: the notion that having a conflict of interest is inherently wrong – and that therefore all conflicts of interests must be avoided.

WHO officials in favour of more engagement with industry may have felt that any more focus on conflict of interest would make *any* collaboration with industry impossible. Others might have been concerned that any more attention to the issue would lead to their being branded as people who have lost their personal and professional integrity.

But neither of these concerns would in fact be realised. Certainly, rethinking and completing the ethical basis for institutional policies governing interactions with the private sector may result in a very different approach to that pursued today under a partnership rubric. It would not, however, make WHO collaboration and other

[32] *See* Boseley 2002; Horton 2002a: 1605–9.

interactions with industry impossible. Instead, it could help staff gain a better understanding of how to judge, justify and appropriately manage a proposed relationship or interaction – or how to reject or abandon it. It could also give renewed impetus to a healthy questioning of the appropriateness of shared decision-making arrangements that decrease citizens' control over public health matters and that are currently being disseminated around the world as a condition of countries being allowed to participate in many global public-private health alliances and initiatives.

How conflict of interest theory may help

The next section of this publication does not aim to draw up a detailed conflict of interest policy for WHO to guide its interactions with transnational corporations, their associations and their wealthy business sponsors. Instead, it aims to provide some basic insights into theorising about conflicts of interest in the hope that this might help resolve some misunderstandings and deadlocks.

It is followed by an exploration of issues linked to WHO's new role as a promoter of the public-private partnership paradigm.

What are conflicts of interest?

When talking about conflicts of interest, most people mean conflicts of interest of individual civil servants (or health professionals) involving money or some form of material benefits. Yet this is not the only issue involved when considering potential risks of close UN-business interactions.

As already indicated, conflict of interest has been defined in several ways. Definitions refer to 'potential', 'apparent' and 'real' (or 'actual') conflicts of interest, as well as 'personal' and 'institutional' ones. Any reader unfamiliar with the topic might well find it all rather confusing. It may therefore be useful to start out with a definition that is relatively easy to grasp. The Merriam-Webster Online Dictionary defines a conflict of interest as:

> "a conflict between the private interests and the official responsibilities of a person in a position of trust."[33]

What this means in practice for citizens, civil servants and health professionals and what should be done about it is not so easy to spell out. Theories about conflicts of

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[33] *See* www.m-w.com/cgi-bin/dictionary

interest and regulations to tackle them will always be a history in the making. Moreover, many issues posed by global public-private interactions are new.

According to Michael Davis, Professor of Philosophy at the Illinois Institute of Technology and a major thinker in the field, the definitive history of the concept of conflict of interest has yet to be written. Davis suggests that 'conflict of interest' started out as a variant of what is today defined as 'conflicting interests'. The notion of 'conflicting interests' usually "designated a clash between a *public* interest and some *private* 'beneficial' or 'pecuniary' interest" (Davis 1998: 594; Davis 2001: 17).

In the late 1960s, lawyers began to connect the term 'conflict of interest' with *judgement*. Davis thus suggests defining a conflict of interest as:

> "a situation in which some interest of a person has a tendency to interfere with the proper exercise of his [or her] judgment in another's behalf." (Davis 1998)

He stresses that the interest that can create a conflict of interest can be "anything that has a tendency to bias judgement."[34] It can be of a financial nature or it can derive from emotions or ties created by family relations, friendship, enmity and other "'subjective tugs on judgment." The central issue with a conflict of interest is that it "renders one's judgment less reliable than normal" (Davis 1998:589, Davis and Stark 2001: 9).

Davis believes that calls for an outright ban on all conflicts of interest assume, mistakenly, that having a conflict of interest is always wrong. He argues:

> "*Having* a conflict of interest is not like being a thief or taking a bribe. What will be morally right or wrong … [depends on whether and] how one resolves that problem." (Davis 1998: 592)[35]

The widespread conflation between *having* a conflict of interest and *acting* in an amoral or illegal way often presents a major obstacle to detecting and/or disclosing conflicts of interest. Yet admitting privately and publicly that a conflict of interest exists is a crucial first step to dealing appropriately with any problems that such a conflict might cause.

Marc A. Rodwin, Professor of Law at Suffolk University Law School in Boston, has conceptualised conflicts of interest in public health. His 1993 book *Medicine, Money and Morals* deals primarily with physicians' financial conflicts of interests within the

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[34] For more details on what such interests can be, *see* Davis 2001: 9.

[35] *See also* Davis and Stark 2001: 13.

United States system of commercialised health care. To explain his conceptual framework, Rodwin refers extensively to how conflicts of interest issues have been conceptualised in other professions, and how they have been understood and handled more generally (Rodwin 1993).[36]

Rodwin's basic concept is similar to, but goes beyond, that of Michael Davis. People have a conflict of interest, says Rodwin, "when their interests or commitments compromise their *independent judgement* or their *loyalty* to individuals they have a duty to serve" (Rodwin 1993: 9, emphasis added). In other words, he regards a conflict of interest as "anything or a situation that can compromise the judgment or loyalty of an actor to the party to which they have a defined legal or ethical obligation to serve" (Rodwin 2003).

Like other analysts in the field, Rodwin distinguishes between 'conflicts of interest' and 'conflicting interests.' People are frequently pulled in different directions, he writes, but "unless such interests compromise known *obligations*, no conflict of interest exists" (Rodwin 1993: 9, original emphasis).

Rodwin, too, found that, despite the widespread use of the term 'conflict of interest', the concept has not been subject to careful theoretical analysis. He draws attention to the ethical and legal underpinnings of the concept.

Rodwin shows that the idea of conflict of interest originated in Anglo-American fiduciary law, particularly the law of trusts and agency. Fiduciaries are individuals that hold property or control the legal affairs for the exclusive benefit of third parties. Because fiduciaries have power over the affairs of others – power that can easily be abused – and because it is difficult to monitor their conduct closely, the law holds them to high standards. Courts have developed various rules to prevent fiduciaries from abusing their trust.[37]

This fiduciary idea spread widely to government law and to the conduct of public servants. In the late seventeenth century, English philosopher John Locke popularized the idea that government should be a public trust and that governmental officials should be regarded as trustees working for the benefit of the public. This idea, along with the notion that representatives in public bodies were agents working for the public, made it easy to import the fiduciary framework to address conflicts of interest.

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[36] *See,* in particular chapters, 1, 7 and 8.

[37] Typically, courts exercise close scrutiny over the conduct of fiduciaries when they have conflicts of interest, that is, when they have interests or commitments that conflict with their obligations to serve their fiducies. Two main kinds of conflict occur:

1. between the fiduciaries' personal interests and the interests of the parties they are supposed to serve; and
2. when fiduciaries have divided loyalties between their obligations to two or more parties (Rodwin 2004).

What does such a fiduciary concept of conflict of interest entail? In relation to government officials and civil servants, it is usually understood that for those working "in the government, public service – rather than profit making – is the rule" (Rodwin 1993: 180-1). Such officials and civil servants are portrayed as holding office for the benefit of those served. The public hands over power to these officials, but in return, they must serve the public.

The public official is seen as a *fiduciary*, a person who has ethical and legal obligations to serve others. The persons served are conceptualised either as 'beneficiaries' or '*fiducies*.' Although this may seem rather paternalistic to those who believe in participatory democracy, ethics and laws governing conflicts of interest have in fact developed as an integral part of modern democracies. The idea of fiduciary obligations in public service has been developed because citizens cannot really check on the details of what public officials and civil servants actually do. As Rodwin explains:

> "Fiducies are seen as vulnerable because they cannot monitor fiduciaries effectively or efficiently. This is why society [in many countries] imposes legal obligations on fiducies to ensure that they act as expected. The law expects fiduciaries *to be loyal* to their fiducies, to be *scrupulously honest* with them, and *to act solely* for their benefit." (Rodwin 1993:183, emphasis added)

Of common intervention strategies to address conflicts of interests, Rodwin says the following:

> "In public service, business and the legal profession, fiduciary loyalty is no longer treated solely as an individual responsibility dependent on the good will and moral integrity of each fiduciary. The development of policy has made public what was once a personal, ethical issue for the fiduciary. The main concerns underlying public policy are the preservation of fiduciary *impartiality* and *independence*, as well as *accountability*." (Rodwin 1993: 207, emphasis added)

Today, the idea of conflict of interest has spread in Anglo-American law still further to encompass those individuals that the law does not consider fiduciaries. It has also found its way into civil law systems that do not have the concepts of trust law or fiduciary (Rodwin 2004).

The primary rationale behind the idea of conflict of interest policies for public officials is to address a central problem of modern democracies: reconciling government power with public accountability. Because public officials are supposed to act in the interests of the public but because the public cannot easily check that they are doing

so, Rodwin stresses that conflict of interest rules serve as an *accountability mechanism*, as well as a *basis for public trust in public institutions*:

> "One way in which we hold public officials accountable is through conflict-of-interest laws. They prohibit public officials from being improperly influenced by private interests or divided loyalties … Conflict of interest rules also help maintain public confidence in government." (Rodwin 1993: 185)[38]

Should all conflicts of interest be avoided?

In recent times, WHO member states have endorsed several policy documents that call on WHO to avoid either '*potential* conflicts of interests' or '*all* conflicts of interests'. Yet such calls do not necessarily lead to policies most suited to addressing the relevant problems. They could, in fact, lead to the paradoxical situation in which actors believe that they are taking the best possible care to avoid problems arising from interacting with commercial actors but may actually be contributing to inaction in addressing the issue appropriately.

An initial problem is caused by the frequent use of the adjective 'potential'. WHO's *Declaration of Interest for WHO Experts*, for instance, asks external scientists to declare whether they know of any 'potential conflict of interest' that could prevent them from serving in a public-interest centred manner on a WHO technical committees. Indeed, much of the conflict of interest literature itself distinguishes between *potential* and *actual* conflicts of interest.

Rodwin finds this distinction unhelpful from a legal perspective and suggests discarding it altogether. Instead, he opts for a distinction between:

- *a conflict of interest* (rather than a 'potential' conflict of interest); and
- *a breach of* [ethical or legal] *obligation*.[39]

Conflicts of interest are not acts, he says. They are *situations* that increase the risk of fiduciaries, consciously or otherwise, making judgements and/or acting in ways that are not in the best interest of their fiducies.

Rodwin stresses that there is nothing morally wrong about having a conflict of interest. He does argue, however, that calling these situations 'potential' conflicts of interest belittles their risks.

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[38] For a summary of US conflict of interest rules for government officials, *see* logo Clark 2001.

[39] Thus, Rodwin calls 'conflict of interest' what others may call 'potential conflict of interest'. He calls 'breach of obligation' (that is, actual acts of disloyal behaviour) what others call 'actual conflict of interest'.

From a legal perspective, conflicts of interest are problematic because "they have the capacity to cause harm – harm must not have occurred." It is this risk – the *potential* of conflict of interest situations to cause harm – that has been the driving force behind societal demands for effective safeguards (Rodwin 1993: 9).

Taking conflicts of interest seriously does not therefore mean that *all* conflicts of interests can or should be avoided. Most interactions with powerful economic actors generate conflicts of interest. Whether or not one avoids a specific conflict of interest or how one manages it depends on a whole range of considerations. These include weighing up the risks posed by the proposed activity or relationship against its potential social value, and linking this risk-benefit assessment to a clear ethical framework – in WHO's case to a framework that treats health as an issue of human rights and social justice.[40]

Taking these considerations into account would lead to a better way of encouraging meaningful and effective action in what Rodwin calls 'coping with' conflicts of interest by demanding that institutions and individuals "*avoid conflicts of interest* ***or manage them appropriately***."

Dealing with perceptions of conflicts of interest

Before exploring what such policies and measures might involve, it is useful to clarify another commonly used phrase used to describe a conflict of interest, namely 'perceived' or 'apparent'.

Once again, this term can easily lead to confusion – as do most dictionary meanings given for the word 'apparent.' Based on the primary meaning of the word, many people might understand an 'apparent' conflict of interest to mean a situation that is "open to view", that is "clear or manifest to the understanding". Others, however, may understand it according to its secondary meaning, as something that is "*manifest* to the senses or mind *as real or true* on the basis of evidence [but] that *may or may not be factually valid*"[41] (emphasis added).

Davis contends that the adjective 'apparent' or phrase '*merely* apparent' is overused when referring to instances of conflicts of interest. He says that the commonly-held

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[40] For more information on how to weigh the risks against potential social benefits, *see* Rodwin 1993: 10, 222. A thorough risk assessment is an indispensable first step. But "the risk posed by a conflict of interest is only one part of the equation. It is important to know the potential benefits from the activities that may be subject to regulation. As the social value of activities increases it makes sense to bear greater risk from conflicts of interest. And for activities that have little social value, society may want to curb conflicts of interest that create even small levels of risk" (Rodwin 1993: 224).

[41] Merriam-Webster Online Dictionary. www.m-w.com/cgi-bin/dictionary, accessed April 2004.

view is that a conflict of interest is merely apparent "if, and only if, [a person] does not have the conflict of interest ... but someone other ... is justified in concluding (however tentatively) that the person has a conflict of interest." He is categorical in his objection to this view: "Apparent conflicts of interest (strictly speaking) are no more conflicts of interest than stage money is money" (Davis 2001: 18).

From this perspective, it is simple to address an 'apparent' conflict of interest. "It is resolved by making available enough information to show there is no actual ... conflict of interest" (Davis 2001: 18). This should be done as soon as possible, believes Davis. If the information made available does not persuade the public, however, then the 'apparent' conflict of interest may well be a real conflict that should be dealt with all the more urgently.

Other analysts see the situation as more complicated. The idea of having rules to address the 'appearance of conflict of interest' or an 'apparent conflict of interest' has been used most frequently in US federal law to govern conflicts of interest that civil servants might face. There are two reasons for legislating against even the appearance of a conflict of interest. First, given the prevalent confusion over what constitutes a conflict of interest, over-inclusive legislation was intended to demonstrate commitment to a high legal standard. Second, the legislation aimed to address the public's perception of conflicts of interest in order to ensure that governments enjoy public trust (Rodwin 2004).[42]

The phrase 'apparent conflict of interest' thus has a range of connotations. As a result, several legal experts regard it as an unworkable subjective standard. They believe that civil servants should not be penalised simply for the appearance of a conflict of interest. Should, then, this term be used at all?

In examining and clarifying interactions between WHO civil servants and private sector actors, I believe it is critical to take seriously apparent, in the sense of 'perceived', conflicts of interest. This is because of the secondary function of conflict of interest policies: to maintain public trust.

As political scientists and public relations professionals know only too well, trust is the fundamental basis of legitimacy for any institution. If people feel that a public official, health professional or scientist with whom they are in a fiduciary relationship is not acting in their interest, they are likely to lose their trust not only in that person, but possibly also in his or her profession and the institution to which s/he is attached.

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[42] Andrew Stark's book *Conflict of interest in American public life* discusses the ambiguities of the 'appearance of official impropriety' (in contrast to 'real official impropriety') in the actions of civil servants. The phrase 'appearance of official impropriety' refers either to the perception that a situation "*looks* like the official did something wrong," or that "the official did something that *looks* wrong". For more information, *see* Stark 2000: 208 ff.

But the challenge for WHO and other UN agencies is not to set up intricate systems to prevent individual civil servants from having 'apparent' conflicts of interest. The main conclusion drawn from theoretical thinking on apparent conflicts of interests is that no public institution should risk losing public trust by neglecting to address people's and the media's perceptions of conflicts of interest. A system to address this should be put in place as a matter of priority.

Strategies to avoid conflicts of interest or manage them appropriately

Setting up detailed and effective conflict of interest measures is a challenge for any institution. Yet it is a challenge that has to be faced head on. The term 'conflict of interest' has become a familiar one to many citizens in the context of relationships between the public and the for-profit sector. How did this term become so well known? Davis and his colleague, Andrew Stark, believe that:

> "The best explanation now available for the recent rise of the concept seems to be the replacement of enduring personal relationships … by the brief encounters characteristic of the free market, big city, and big business. We are now much more dependent on the judgement of others, much less able to evaluate their judgement, decision by decision, and indeed generally know much less about those individuals than we would have even fifty years ago." (Davis and Stark 2001: 17)

Political scientists may have a slightly different explanation for increased interest in the issue. The history of conflicts of interest encountered in public life shows that meaningful measures to address the problem have often been instituted only after public concerns have been voiced about gross abuses on the part of those holding public office. In the US and the UK, for example, the history began when concerns were raised about corrupt public officials. Efforts to regulate bribery and corruption evolved into more complex conflict of interest policies when it became clear that hidden payments were not the only way in which powerful economic actors tried to influence public officials or the decision-making processes in public institutions. Other avenues include honoraries for consultancies and public presentations, and a whole gamut of donations, sponsorships and gifts as well as the implicit or explicit promise of a highly paid private sector job once the public official leaves office.[43]

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[43] For more details of this history, *see*, for example, Williams 1985: 12–16.

In the biomedical field, there has long been a debate about how to ensure the integrity, independence and loyalty of physicians, researchers, medical journals and drug regulators to their respective fiducies given that they all now operate in a medical-industrial complex.[44]

As previously stated, there are two overall reasons for enacting conflict of interest measures: to ensure accountability and to maintain trust. Ensuring accountability has three further important dimensions: prevention, monitoring and remedial action.

Conflict of interest policies and laws have primarily evolved as *preventive* measures. Well-defined conflict of interest policies aim to address the risks caused by conflicts of interest and to help civil servants know and recognise the limits of their discretionary decision-making powers. They help *monitor* what is actually going on. And finally, conflict of interest policies and laws also have a *remedial* function. They help to redress and compensate for wrongs. If civil servants overstep the boundaries, they can be held accountable for breaches of defined obligations.

How can institutional and public policies be put in place to deal appropriately with conflicts of interest? Three basic strategies underlie comprehensive conflict of interest policies:

1. *Prevention (protection of fiducies by prophylactic measures)*
Disclosing conflicts of interest and prohibiting fiduciaries from entering into a situation or relationship in which serious conflicts of interest occur (for instance, restricting government officials from working with business for a limited period after they have left public office).
2. *Supervision through regulation*
Reducing discretionary decision-making powers.
3. *Sanctions and restitution*
Providing remedies if fiduciaries abuse their trust or harm fiducies (Rodwin 1993: 207–8).[45]

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[44] This term was coined by US intellectual Barbara Ehrenreich in 1970 (Rodwin 1993: 13).

[45] Many policy makers and health professionals are not comfortable with more public regulation of conflicts of interest. They advocate disclosure of conflicts of interest as *the* alternative. But there are limits to disclosure. Experience shows that disclosure can help to address conflicts of interest only if it is part of a coordinated policy that: (1) "sets high standards of ethical conduct; (2) clearly delineates the permissible from the unacceptable; (3) develops institutions to monitor behaviour; and (4) imposes meaningful sanctions to ensure compliance" (Rodwin 1993: 219).

In sum, conflicts of interest that professionals might face are tackled by means of three regulatory approaches:

1. Prohibiting certain kinds of activities;
2. Regulating and monitoring conduct;
3. Providing penalties for improper conduct (Rodwin 1993: 225).

A fourth indispensable component of an *institutional* conflict of interest policy is a well-articulated provision for institutional public disclosure to allow for independent, public oversight. In WHO's case, this provision should include making available information that would allow WHO's member states, public interest groups and the media to reinforce the work of those who regulate within the UN agency the conflicts of interest that are generated by the various public-private interactions and joint initiatives.[46]

It is essential that intergovernmental public institutions are transparent and open to public inquiry. This would allow the public to judge for themselves whether or not the institution and its employees are acting in the best public interest. It would also go a long way towards maintaining people's trust in UN agencies as it would demonstrate that the agencies have nothing to hide. Transparency and openness may also help dissipate the widespread and growing perception that the increase in the volume and closeness of the interactions between UN agencies and private sector actors in recent years has increased the number of unacceptable and unchallenged conflicts of interest.

WHO's Secretariat can demonstrate that it takes these public perceptions seriously by:

1. clarifying and widely publicising its institutional policies for its interactions with commercial actors and its measures to safeguard public interests (including its current ethical reference framework and conflict of interest rules and procedures); and
2. setting up channels to investigate and respond quickly and openly to any allegation of a conflict of interest.

Safeguarding public interests in an era of global public-private partnerships

The academic and theoretical literature on conflict of interest deals at length with personal conflicts of interest, but is far less conclusive about issues that go beyond the individual.

For instance, how useful is it to focus on holding individuals – in WHO's case, international civil servants – accountable by means of conflict of interest rules (except

[46] *See also* Rodwin 1993: 189–189, 218.

for higher-level officials) when their institution may be so enmeshed with for-profit interests that it restricts the individual's freedom of decision-making? Should such problems be dealt with by focussing on the development of policies addressing 'institutional conflicts of interest'? Or should they be dealt with from different, possibly broader, value-based political perspective?

For example, researchers in the medical field are usually held to both unspoken and to formulated codes of ethics to guarantee the scientific integrity of their research and to ensure that the resulting knowledge is disseminated to other research institutions and the public. Some countries have instituted a whole range of conflict of interest and other rules to protect the integrity of medical research.

Tufts University professor Sheldon Krimsky has analysed changes in the United States that have occurred in the past two decades because of the rise of the 'entrepreneurial university' and of government incentives for university-industry partnerships. Krimsky's research raises issues that can no longer be prevented or managed by existing conflict of interest regulations.

Among the adverse effects of these changes – effects that are frequently overlooked – are the erosion of academic or research ethics, the replacement of openness by secrecy, and an unprecedented rise in conflicts of interest such that most researchers now accept conflicts of interest as the norm rather than as an exception to be justified.

Krimsky draws attention to the inestimable cost for society caused by the production of science in the private interest: a loss of funding and opportunity for 'public-interest science', which includes scientific research on the risks and problems caused by environmental pollutants and on the harmful side-effects of pharmaceutical drugs (Krimsky 2003).

What particular problems have been created by WHO's embrace of the public-private partnership paradigm? What are some possible solutions to these problems?

Implicit assumptions of the partnership model

The consequences of UN agencies' pursuit of the public-private partnership paradigm have not only been an increase in relationships between the agencies and the private sector, many of which have existed for some time. The framework of thought underlying the partnership paradigm has also encompassed demands for a profound restructuring of the way in which public and other 'partners' are meant to interact with the private sector.

One of the key features of these newer partnerships is the 'shared process of decision-making'. This could well mean that conflicts of interest are built into the very design of public-private 'partnerships'.

Other implicit key assumptions underlying the current PPP paradigm are that:

- interactions with business actors should be based from the outset on 'trust';
- they should aim at 'mutual benefits';
- public-private 'partnerships' represent a 'win-win' situation (or even 'win-win-win' in the case of tri-sector 'multi-stakeholder' interactions); and
- this policy paradigm is *the* policy innovation of the new Millennium – or is simply a necessity because there is no alternative.

'Partnership-building principles' and critical scrutiny of public-private interactions

An uncritical approach to partnerships with the commercial sector was reflected in the 1999 preliminary WHO *Guidelines for Interaction with Commercial Enterprises*, which included some of these underlying assumptions. For instance, the introductory section outlining the purpose of the Guidelines stated that "WHO must increasingly see its role as one of harnessing support from among a variety of players." It stated that WHO "needs to create sound partnerships with public bodies, civil society and commercial enterprises to make health everybody's business."

The preliminary Guidelines' objective was not just "to guide the relationship between commercial enterprises and WHO" but also to "provide an innovative and *positive* approach to cooperation and partnership with the commercial sector."

They reiterated the need to maintain WHO's position as an impartial holder of health values and scientific validity, but stressed at the same time '*general principles of partnership-building*', which the document identified as "mutual respect, trust, transparency, and shared benefit" (WHO 1999: 2, emphasis added).

The section describing the purpose of the 1999 Guidelines came in for heavy criticism when they were reviewed by WHO member states and public interest NGOs.[47] The core of the criticisms was that the Guidelines contained value-laden statements about 'partnerships' and that the principles of partnership building would interfere with those values and attitudes that are essential for weighing up the benefits of a proposed interaction with a commercial actor against its risks and costs. Public interest networks and organisations whose work includes monitoring activities of transnational corporations have repeatedly asked that WHO refrain from using the term partnership for interactions with the commercial sector. For example, the International Baby Food Action Network stated during the Guideline debate:

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[47] For a summary of some NGO comments on the Guidelines, *see*, for example, Richter 2003: 11–14. For the WHO summary, *see* WHO 2000d.

> "IBFAN recommends replacing the word 'partnership' with 'interaction' wherever references are made to WHO and commercial enterprises. The 'partnership' discourse anthromorphises corporations and risks blunting the critical faculties which are essential for the assessment of the potential pitfalls of a too close and trusting interaction. 'Caution' and healthy distrust seem to be the appropriate attitude for dealing with commercial enterprises, many of which are currently involved in a public relations exercise aiming to represent themselves as 'responsible corporate citizens' who should be allowed to operate with a minimum of outside interference or regulation." (IBFAN 1999: 3)

As far as the role of international civil servants in these partnerships is concerned, the criticisms can be summarised as follows:

- 'respect' cannot simply be given (or requested or 'built') – it has to be earned;
- unquestioning 'trust' risks interfering with the spirit of caution and scepticism needed for a proper evaluation of a proposed interaction;
- 'shared (or mutual) benefits' are an inappropriate standard by which to assess the benefits of a particular public-private interaction. The duty of public servants is to ensure that any proposed arrangement benefits to the full the public that WHO is meant to serve. (There is no need, moreover, for civil servants to ensure that the private sector party gains benefits. The managerial, operational and even public relations staff of the company, business association or foundation involved will assume this task.)

WHO's Secretariat took these criticisms on board when it revised the Guidelines. The *Guidelines on Interaction with Commercial Enterprises to Achieve Health Outcomes* largely replaced the term 'partnership' by less value-laden descriptions such as 'interactions' and 'alliances'. The principles of partnership building were removed, and the statement of purpose now simply says:

> "These guidelines are intended primarily to help WHO staff interact appropriately with commercial enterprises in order to achieve positive outcomes for health."

The principle of transparency was not explicitly retained in the revised Guidelines. But the statement of purpose declares that the *Guidelines for Interaction with Commercial Enterprises* will be posted on WHO's website (WHO 2000b: 2), a first practical step towards transparency.

Even though the revised Guidelines took into account criticisms of the underlying problematic assumptions of the partnership paradigm, the overall approach of WHO as an organization has not really changed. Many of the assumptions underlying the

partnership approach continue to prevail, in particular at the higher staff levels of the Organization (*see* Chapter Four).

In the current climate of public-private partnerships, moreover, a cautious or inquisitive attitude shown by a civil servant to a proposed interaction with a private sector actor is often described as evidence of an 'adversarial' attitude towards the private sector.[48] This interpretation has exacerbated the frustration felt by experienced international civil servants who have long dealt with the complexities of such interactions and strived to ensure that they operate in the public interest. Some have left the various UN agencies because they felt they could not maintain their integrity in such a climate.[49] They are gradually being replaced by civil servants who go along with what is presented as a more 'pragmatic' approach. There is an urgent need to re-value and strengthen caution and inquisitiveness as appropriate attitudes for civil servants to adopt when interacting and negotiating with powerful commercial actors who are operating in an increasingly competitive world.

A 'win-win' paradigm?

Another widespread perception is that entering into 'partnerships' with commercial actors is a win-win situation for all concerned. Accepting this assumption at face value carries large risks.

There are undoubtedly some interactions in which all parties have something to gain and which are fully in the public interest (for example, in the development of pharmaceuticals for neglected diseases, if these initiatives are well circumscribed with appropriate safeguards for public interests). But an emphasis on 'win-win' tends to lead to biased assessments. A more appropriate assessment needs to ask 'who-wins-what' and 'who-loses-what'. Gains or 'wins' for the commercial sector should not be based on, or result in, losses from a public interest perspective.

Such losses, trade-offs and concessions can be far-reaching. Some broad and well-established risks for society of the policy trend towards partnerships between the public and private sectors include:

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[48] For example, Harvey E. Bale of The International Pharmaceutical Manufacturers' Associations (IFPMA) described the Guidelines as being "industry unfriendly." According to him, they displayed a negative bias against the private sector, which he saw as conflicting with WHO's expressed interest in partnerships. He criticized WHO's approach to industry as overly defensive and suspicious and in marked difference to the approach taken by other international organisations (WHO 2000d: 2).

[49] For reasons why the former editor of WHO's Essential Drug Monitor left, *see for instance*, Horton 2002a

- commercial actors using the interaction to gain political and market intelligence information in order to gain political influence and/or a competitive edge (over companies that are not interesting enough to be 'partners' for UN agencies);
- business actors using the interaction to set the global public agenda;
- business actors using the interaction to 'capture' and/or sideline intergovernmental public agencies;
- UN agencies developing an internal climate of censorship and self-censorship; and
- a weakening of efforts to hold transnational corporations publicly accountable to society for their practices and actions (Utting 2000: 32, Richter 2003b).

For business partners, however, the balance between the potential risks and gains of an interaction with a UN agency (or public interest group) looks very different. A few years ago, a study on Global Public Private Partnerships for Health published in the *Bulletin of the World Health Organization* concluded that:

> "For the corporate sector, partnerships have (1) increased corporate influence in global policy making and at the national level; (2) brought direct financial returns, such as tax breaks and market penetration, as well as direct financial benefits through brand and image promotion; (3) enhanced corporate authority and legitimacy through association with UN and other bodies."

As the authors pointed out, "the costs for the private sector seem to be relatively small in relation to overall gains: a potential small loss of resources if programmes do not work but huge benefits in public relations when they succeed" (both quotes, Buse and Walt 2000b: 706).[50]

For the for-profit sector, in particular for those corporations who 'partner' with UN agencies, the UN's shift towards accepting the public-private partnership paradigm has already paid off well. From a public interest perspective, however, many of the gains for the corporate sector are losses. They are reflected in the weakening of the ability of the UN agencies, their member states, and the world's citizens to exercise control over decision-making in the area of health policy-making, standard setting and advocacy of public interests.[51]

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[50] There is the risk, however, of negative publicity if public attention is drawn to the potentially problematic motives of the business party.

[51] Many analyses of public-private partnerships focus on either the benefits or an evaluation of specific public-private initiatives. Broader issues linked to the paradigm shift do not receive the attention they deserve.

Blurring of distinctions between societal actors

One of the most substantive losses resulting from the shift towards the partnership paradigm is the loss of distinction between different actors in the international health arena. UN agencies, governments, transnational corporations, their business associations, and public interest NGOs are all indiscriminately called 'partner'.

The realisation that these actors have different, possibly conflicting, mandates, goals and roles has, as a result, also been lost.[52] One recent analysis of the partnership trend as part of a more general shift within international relations pointed to another political consequence:

> "It is problematic to use the term 'partnership' to characterize the relationship between state and non-state actors, because what the term suggests is an … equal status for the actors involved. This relativizes both, the special political status of governmental institutions under international law and their (democratic) legitimacy. The use of terms like 'partnerships' is … not just a matter of stylistics, it has eminently political significance. It implicitly downgrades the role of governments and intergovernmental organisations and upgrades the (political) status of private actors, in particular of the transnational corporations involved in these cooperation models." (Martens 2003: 26)[53]

Checks and balances

Assessment of the evolution and current state of WHO's public interest safeguards suggests that the stumbling blocks towards putting more comprehensive safeguards in place and linking them firmly to an underlying ethics and conflict of interest framework are as much political as they are caused by the complexities of the issue.

The rise of the partnership paradigm has meant that measures to deal effectively with conflicts of interest are regarded not as safeguards but as obstacles. The underlying assumptions of the partnership paradigm and its accompanying terminology have blurred the roles of different actors within institutional and international policy arenas.

Conflict of interest theory may help to overcome some of these stumbling blocks and ensure a more coherent, ethics-based policy to guide WHO's public-private interactions in the field of health.

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[52] This would suggest that problems today go beyond what might be called 'institutional capture'.

[53] For another interesting exploration, *see also* "Partnership: What's in a name?, *in* Zammit 2003: 51–54.

There is now a fair amount of knowledge and thinking about conflicts of interest generated by interactions between economic and other societal actors in many fields. Relevant knowledge and thinking can be found in the literature on conflicts of interest in public service, medical research and science and in treatises on how to ensure democratic decision-making in a globalising world. This would need to be complemented, however, by a thorough analysis of the experiences of WHO staff who have been involved in cooperative relationships with private sector actors and those who have managed to fend off industry pressure on WHO to enter into relationships that the staff regard as conflicting with WHO's mandate or core functions or as posing a risk to WHO's reputation as the UN agency striving for Health for All.

Since 1998, one problem in learning from this experience has been that the focus of attention has often been narrowed down to the tobacco industry. Several WHO officials, including Dr. Brundtland, have made a stark distinction between tobacco manufacturers, which they describe as ruthless marketers of a killer product, and other industries, which are portrayed as producers of health-related products and thus as potential sponsors or project and dialogue 'partners' (or 'stakeholders') with whom interactions should be encouraged.

Lessons which can and should have been drawn from experience with the pharmaceutical, infant food, junk food and alcohol industries over the past two decades[54] are all too often dismissed as stemming from an outdated 'adversarial' framework (confounding 'arms length' with 'inimical' approaches). Or they are described as an obstacle to more 'constructive' and 'innovative' ways of engaging with commercial actors.

For example, food industries and organisations founded by or close to the food industry were 'stakeholders' in discussions on WHO's *Global Strategy on Diet, Physical Activity and Health*. Concerns that such industry involvement in the policy-making process might dilute the strategy, particularly plans to recommend regulating the marketing of junk foods and soft drink high in sugar content to children, were not taken seriously enough. WHO's project manager stated repeatedly that "food is not tobacco". She argued that tobacco kills half its users, while "this is not the case with food" given that "we all need to eat and wish to enjoy the food we consume" (Waxman 2003). WHO tried to win member states, public interest and professional organisations over to a policy of positive engagement. The result is a *Global Strategy on Diet* with

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[54] For example, Chetley 1990; Kanji et al. 1992; Gellman 2000a; Gellman 2000b; Velásquez 2004; Richter 2001; Cabasse 2004; Rundall 2000; Babor, Griffith et al. 1996; Hirschhorn 2002; Boseley 2003a; Boseley 2003b; Alden et al. 2004; Down to Earth 2004; Commercial Alert 2004.

many positive elements but also with many shortcomings, the seriousness of which can be assessed fully only once the Strategy starts to be implemented.

In considering how to reclaim a clearer baseline of values by which to assess interactions with the private sector, it must be emphasized that developing an appropriate strategy to safeguard public interests needs above all an understanding that conflict of interest policies evolved as an important (but not the only) part of intricate systems of *checks and balances* in democracies, medicine and the sciences. Their development and implementation should not be seen as troublesome task, but rather as a key prerequisite to a well-functioning public institution.

Some parts of such systems can be formalised, others not. At issue is the need to recover, maintain and strengthen institutional and societal environments that encourage internal and external checks and balances to ensure that close proximity to money and power does not lead to harmful consequences for public interests, that it does not corrupt.

Facilitating the input of public interest NGOs

When Dr. Brundtland presented WHO's existing or envisaged measures to manage public-private interactions and conflicts of interest to the Executive Board in January 2002, she seemed to take the question of balances of power and external checks into consideration. The measures she outlined explicitly referred to WHO's newly founded Civil Society Initiative (CSI) and its task of facilitating "the input of nongovernmental organizations views pertaining to public-private interactions" (WHO 2001: 3) (*see also* Box 1, p. 16).

To what degree was there a high-level commitment to facilitate independent critical input into debates on public-private interactions (other than the debate on the Framework Convention on Tobacco Control)? The CSI had the potential to do so, but its work in practice has increased the risks of industry gaining yet more opportunities for influence in the international health arena and of weakening the input of those civic actors that have historically acted as corporate watchdog groups.

The Civil Society Initiative

Dr. Brundtland launched the Civil Society Initiative at the World Health Assembly in 2001 as part of her overall 'outreach' effort. The stated purpose of the Initiative was to collect and analyse material and to consult with a broad range of actors within and outside of WHO to identify and develop propositions for more effective and useful interactions and relationships between civil society and WHO. When this work started,

civil society was defined as including social movements, voluntary associations, NGOs, grassroots organisations and other non-state, not-for-profit actors (*in* WHO/CSI 2002: 2).

The Civil Society Initiative did initially seem to work towards its stated purpose. Its 2002 Review Report, which summarised the findings of a consultation process, mentioned that WHO had benefited from civil society organisations' (CSOs) watchdog function in protecting public health and from their ability to raise "sensitive issues that WHO, as an intergovernmental organization, may not be in position to address for political reasons." It also mentioned that greater involvement of civil society organisations might help democratise international relations and increase transparency and public accountability in international policy development (WHO/CSI 2002: 13).

Its report highlighted a number of key concerns raised by civil society organisations during the consultations, in particular:

1. The lack of distinction in WHO's 1987 NGO relations policy between public interest NGOs (PINGOs) and business interest NGOs (BINGOs); and
2. The insufficiency of WHO's safeguards on conflicts of interest (WHO/CSI 2002: 14).

It stated that civil society voices were urging that "business-linked organizations be classified as the private (for profit sector) and not fall within the NGO/CSO classification" and that WHO "build on WHO's Guidelines for interactions with commercial enterprises and supplement them with additional measures" in order to appropriately deal with conflicts of interest (WHO/CSI 2002: 9; 14).

Why then did the Civil Society Initiative not take these comments into account when updating the 1987 *Principles Governing Relations between the World Health Organization and Nongovernmental Organizations* (WHO 1987)?

New WHO policy for official relations with NGOs

The draft of a new *Policy for Relations between the World Health Organization and Nongovernmental Organizations* (henceforth WHO's NGO relations policy) was posted on WHO's website in November 2002 and described as the outcome of a desk review and consultation process (WHO 2002). During a WHO briefing session for NGOs one month later, some initial questions about the revised policy were raised.

Why, for instance, did the policy not distinguish more clearly between business interest and public interest actors? If the policy was to include business actors within its scope, why did it not make a clear reference to the WHO *Guidelines for Interaction with Commercial Enterprises to Achieve Health Outcomes*?

When the Civil Society Initiative introduced the draft WHO-NGO relations policy at the Executive Board in January 2003, several Executive Board members voiced

similar criticisms to those raised by NGOs. They welcomed the idea of subdividing the policy into an 'Accreditation Policy' and a 'Collaboration Policy,' but were concerned that, on the whole, the policy was formulated in a way that might increase the influence of the commercial sector over public policy-making and multiply conflicts of interest. Ghana, Brazil and Colombia demanded that the policy make a clearer distinction between organisations that served the public interest and those that represented or were closely linked to business interests. Some member states highlighted the need for WHO's mechanisms to safeguard its independence, objectivity and reputation to be improved and strengthened further.

The United States agreed that clearer legal and ethical principles should be established to deal with conflicts of interests, but opposed 'singling out' for-profit organisations. In the opinion of the US delegate, there were many non-profit organizations, including governments that did not always have the best interests of the public at heart.

The US delegate specifically requested that a paragraph in the draft policy stipulating that "collaboration with nongovernmental organizations representing commercial interests shall also follow WHO mechanisms and practices for interacting with commercial enterprises" be deleted because he saw the language as too narrow. He argued, furthermore, that WHO's Executive Board had never officially approved the mechanisms and practices for interacting with commercial enterprises.

Ghana's representative stressed, however, that the criticised paragraph should not only remain but be further strengthened by making explicit reference to the *Guidelines on Interaction with Commercial Enterprises to Achieve Health Outcomes* (WHO 2003b: 170–178).

Controversial debates continued at the 2003 World Health Assembly. Questions were raised as to the appropriateness of changes that had been introduced in the draft policy after the Executive Board meeting in January 2003. Why, for example, had WHO expanded the proposed new definition of nongovernmental organisations to explicitly include "*non-for-profit organizations that represent or a closely linked with commercial interests*" (WHO 2003c, para 3)?

Debate was curtailed by China's last minute tabling of extensive changes aimed at gaining more government control over NGOs rather than facilitating their interactions with WHO.

Reaching agreement on both China's proposal and diverging views on the accreditation of and collaboration with not-for-profit business interest actors was clearly going to take some time. Thus the World Health Assembly deferred further debate on the draft policy to the 2004 Executive Board meeting.

The draft was tabled, unchanged, at this Executive Board meeting. But discussion was limited because the WHO Secretariat, in consultation with Executive Board members, had already decided to refer the matter to a working group of member states

to discuss the policy and the accompanying resolution and to present proposals to resolve the contested issues at the 2004 World Health Assembly.[55]

Public interest NGOs pointed out in their statements to the Executive Board that the new expanded NGO definition constituted a fundamental shift from WHO's 1987 *Principles Governing Relations between the World Health Organization and Nongovernmental Organization.* They reiterated their suggestion that WHO should establish a private sector category that was distinct and separate from civil society, including NGOs. They called for an independent external review of all the mechanisms to safeguard WHO's integrity and independence.[56]

A representative of the International Special Dietary Food Industries (ISDI), meanwhile, spoke out at the January 2004 Executive Board meeting in favour of adopting the draft policy as tabled because:

> "The United Nations community recognizes the industry as an important *stakeholder and partner.* UN organizations have long recognized that *NGOs* representing consumers, business and industry are important sources of knowledge, technology and resources." (ISDI 2004a, emphasis added)

The representative rejected any measure aimed at distinguishing between not-for profit entities representing commercial interests and other not-for profit actors on the grounds that this would constitute unjust discrimination. The ISDI was categorical that "all NGOs should be afforded the same rights to participate and collaborate in WHO processes, including access to the WHA and Executive Boards sessions" (ISDI 2004a).

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[55] An item on the Executive Board meeting's January 2004 agenda before the draft NGO policy highlighted the issue of accrediting business interest organisations as NGOs in official relations with WHO. The Executive Board's Standing Committee on Nongovernmental Organizations had recommended that two industry groups be admitted into official relations with WHO: the International Council of Grocery Manufacturers Associations (ICGMA) and the Confederation of the Food and Drink Industries of the EU (CIAA) (WHO 2004a). Its recommendation document was issued on the morning of 23 January, the very day on which member states were to consider approval of the recommendation.

Thirteen member states spoke on the issue. Some pointed to the discrepancy between the Standing Committee's recommendation and WHO's existing (and still valid) 1987 NGO policy. The questions and objections from the floor resulted in the Board postponing a decision on the two applications until further information had been obtained on both industry groupings and their links with the tobacco industry.

[56] CI et al. 2004, Infact 2004. *See also Summary of Key Concerns Regarding the Proposed WHO Policy for Relations with Nongovernmental Organizations*, IBFAN et al. 2003.

The International Pharmaceutical Manufacturers Association (IFPMA) also expressed its opposition to any attempt to identify business interest actors more clearly. Both industry groupings stressed their long-time 'partnerships' with WHO and their multi-sector cooperation.

Following the 2004 Executive Board meeting, three closed meetings of the member states' working group took place. Their suggested changes to the draft policy, however, did not include a clearer distinction between business and other societal actors. The NGO definition remained unchanged and continued to identify business interest actors as nongovernmental organisations:

> "An organisation that is not established by a governmental entity of intergovernmental agreement shall be considered a nongovernmental organisation ... For the purpose of this policy, nongovernmental organisations include a wide range of organisations, such as groups that represent consumers and patients, associations with humanitarian, developmental, scientific and/or professional goals and not-for-profit organisations that represent or are closely linked with commercial interests." (WHO 2004b: 3, para 4)

This definition, if accepted, could well result in increased avenues for industry influence in the international health arena.

But the member states' working group did put two paragraphs into the draft resolution requesting:

> "the Director-General to establish suitable measures to implement the policy, including... clear and specific guidelines on avoiding conflict of interest" (WHO 2004b: 2, para 3); and that

> [the Director-General to institute, [an external, independent review of] mechanisms to safeguard WHO's integrity and independence, including the WHO's Guidelines for Interactions with Commercial Enterprises]. (WHO 2004b: 2, para 5)

The brackets around, and in, the second paragraph indicate that the second request was highly contested within the meetings of the member states' working group. Whether both paragraphs would be retained and the policy adopted at the May 2004 World Health Assembly would depend on political will, power balance and negotiation skills.

Towards a review of WHO's safeguards?

Before the May 2004 World Health Assembly, any prediction as to the outcome of the debates on the *Policy for Relations between the World Health Organization and Nongovernmental Organizations* was difficult to make. Clearly, retaining the second paragraph in its entirety could be a promising step towards more clarity in WHO's public interest safeguards. Any hopes of this, however, were short-lived.

The debate among the WHO member states on the resolution and policy was brief. It focused on China's wish for more control over NGOs, with three countries (China, Pakistan and Cuba) arguing in favour of more government control. Sweden spoke against such a move, stressing its support for democratic traditions. Canada, USA, The Netherlands and the UK said that they too could not support this section of the draft policy. Canada thus suggested postponing any decision on the NGO policy until the final report of the UN Secretary-General's *Panel of Eminent Persons on United Nations-Civil Society Relations* was published. The various positions of the member states were too far apart for any consensus to be reached. The 2004 World Health Assembly thus decided "to provide the Director-General with time to consult all interested parties with a view to reaching consensus on the terms of the relevant resolution to be submitted to a subsequent Health Assembly through the Executive Board." Following this decision, public interests and other NGOs were given the floor.

The food and pharmaceutical industries repeated the positions they had presented at the January 2004 Executive Board meeting. The ISDI suggested that "non-discrimination" should become one of the two core principles on which any WHO-NGO relations policy should be built (ISDI 2004b).[57] [58]

Several public interest advocacy networks responded that the industry groupings' concern about negative discrimination was unwarranted. Collaboration with business

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[57] On the ISDI website is a statement from the organisation for the WHA 2003 (which to my knowledge was not delivered). This states that efforts to reform accreditation and collaboration requirements for NGOs "must retain the principle of non-discrimination instituted in the current WHO policy and guidelines" (ISDI 2003). In other words, "All NGOs should be afforded the same rights to participate and collaborate in WHO processes, including access to the WHA [World Health Assembly] and Executive Board sessions" (ISDI 2004a). It seems that the industry even rejected as discriminatory a plan to distribute different coloured badges for business interest organisations and other NGOs (a measure that had been envisaged to allow member state delegates discern to whom they were talking when being approached by NGO representatives).

[58] The other was 'transparency.' According to this industry association: "all NGOs should be subject to the same high levels of scrutiny, and accountability and should be required to disclose affiliations and funding sources, and demonstrate that they do, in fact, represent the constituency they claim to represent" (ISDI 2004a).

associations clearly came within the scope of the *WHO's Guidelines on Interaction with Commercial Enterprises*. These Guidelines defined commercial enterprises as "businesses that are intended to make profit for their owners", but encompassed a variety of other institutions as well, "including … associations representing commercial enterprises, [and] foundations not at arms length from their sponsors" (WHO 2000b, para 2 & 3). The NGOs suggested that WHO refine this definition further and think afresh on policies for accreditation (CI et al. 2004).

The future of the draft WHO-NGO relations policy is uncertain. Will it be resolved so as to genuinely facilitate civil society actors' contribution to the work of WHO and its member states for Health for All? Does its postponement at the 2004 World Health Assembly to an unspecified 'subsequent' Executive Board meeting and World Health Assembly augur its death-knell? Or will associations of transnational corporations actively lobby for the adoption of a version that further facilitates their acceptance as NGOs in official relations with WHO?

Canada hoped that the UN Secretary-General's *Panel of Eminent Persons on United Nations-Civil Society Relations* might clarify some of the issues.[59] But given the Panel's terms of reference and the trajectory of its work, it is doubtful that its report will help to resolve issues as to whether industry associations should be specifically included within UN NGO definitions or will raise questions about the potential for this NGO status to enable the associations to gain undue industry influence in public affairs.[60]

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[59] Thanks to Lida Lhotska, IBFAN-GIFA, for sharing her notes of the May 2004 Executive Board meeting.

[60] The High-Level Panel's terms of reference are themselves confusing. Their task is to advise the UN Secretary-General on priorities for "enhancing interaction between the Organization and *civil society*, *including* parliamentarians and *the private sector*" (emphasis added).
In a working paper, the Panel tried to make a better distinction between different actors but stressed that its results were not an official UN classification. It defined 'civil society' as "the associational activity of citizens (outside their families, friends and workplaces) that is entered into voluntarily to advance their interests, ideas, ideals and ideologies. It doesn't include associational activity of people for profit-making purposes (the private sector) or for governing (the state or public sector)." The Panel defined 'private business sector' as including "for-profit firms, their federations and philanthropic initiatives emanating from firms" (UN 2003a).
This distinction was lost, however, in the summary of a Multi-stakeholder Workshop on Partnership and UN-Civil Society Relationships held by the High-Level Panel. Under the heading 'Civil society' and 'other actors', it states that "It is important to be inclusive in our conception of civil society, to look beyond the 'usual suspects' and seek out the potential contributions and roles of diverse actors including not only NGOs but also professional associations, local authorities, organized labor, private sector, faith-based and community-based groups and 'unorganized' social movements. Although groups such as parliamentarians, local government and private sector are not traditionally seen as belonging to 'civil society', the UN has a practical need to engage with all these diverse actors to achieve global goals" (UN 2004).

Ever since the UN first created the category of nongovernmental organization in 1946 for not-for profit, non-state actors, industry associations have been able to apply for, and usually obtain, NGO status on the basis that they, too, are not-for-profit. Their admission as NGOs in consultative status has depended on two long-standing practices:

1. conflating 'not-profit making' and 'not working in the interest of profit' (an organization might well itself make no profits, but its aims and objectives are to work in the interest of others' making profits); and
2. disregarding another requirement for UN NGO status, namely that the organisation should share the UN's values.

For example the 1996 UN's Economic and Social Council's Resolution on *Consultative Relationships between the United Nations and Non-governmental Organizations*, which currently governs decisions as to which NGOs gain consultative relationship status with the United Nations, specifies that "the aims and purposes of the organization shall be in conformity with the spirit, purposes and principles of the Charter of the United Nations" (ECOSOC Resolution 1996/31, para 2).

Similarly, WHO's 1987 *Principles Governing Relations between the World Health Organization and Nongovernmental Organizations* require that the NGO's "aims and activities shall be in conformity with the *spirit, purposes and principles* of the Constitution of WHO" (WHO 1987, para 3.1, emphasis added).

There are exceptions, however, to the routine admission of non-profit making business associations as UN NGOs. In the early 1980s, for example, WHO's Executive Board deferred the application of the International Council of Infant Food Industries (ICIFI) three times because of evidence that the industry association members had been undermining WHO members states' implementation of the International Code of Marketing of Breast-milk Substitutes and had continued pursuing harmful marketing practices. The infant food manufacturers thus changed their strategy. They dissolved ICIFI and formed another business association, the International Association of Infant Food Manufacturers (IFM). This association asked WHO's Secretariat what its chances were of being accepted as an NGO in official relations with WHO. When it learnt that its chances were not good, it joined an existing industry body, the International Society of Dietary Food Industries (ISDI). This industry umbrella association then applied for the status of an NGO in official relations with WHO, which it gained in 1987.[61]

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[61] The infant food industry shared its experience with other TNCs in a newsletter on 'How companies can gain from NGO status'. For more details, *see* Allain 1991: 26–7, 36; Chetley 1986: 28, 81, 148–9; Sethi 1994: 23.

Interestingly, in 2004, WHO member states once again adopted a more critical attitude towards business associations, probably because of their heightened awareness of successful industry resistance to the adoption of a strong *Global Strategy on Diet, Physical Activity and Health*.[62]

Such awareness had led the January 2004 and May 2004 Executive Board meetings to defer the admission of two other food industry groupings – the International Council of Grocery Manufacturers Associations (ICGMA) and the Confederation of the Food and Drink Industries of the EU (CIAA) – as NGOs with official relations status with WHO.

A few member states, in particular the United States, regarded this deferral as inconsistent with the anticipated 'multi-stakeholder' implementation of the *Global Strategy on Diet*. The US delegate seemed to interpret multi-stakeholder initiatives as unconditional blanket admissions of industry to all discussions. Other member states pointed out that, in fact, WHO consultations with these associations did not depend on their having the status of NGO with official relations. WHO and its member states can consult with industry and their associations if they see this as being in the public interest.

Several countries expressed their discomfort that the role of TNCs in implementing the *Global Strategy on Diet* is poorly defined and that some of the member companies of the Grocery Manufacturers Association had ties with tobacco companies. During the May 2004 World Health Assembly debate on the *Global Strategy on Diet*, the European Union representative had suggested that the role of TNCs should be reviewed in the near future and pointed to the Framework of Convention on Tobacco Control as a document that more clearly defined appropriate industry roles (EU 2004).[63] [64]

As of June 2004, it is uncertain whether the WHO Secretariat and member states will find new vigour and political will to work on two different sets of accreditation and collaboration policies for NGOs, one for civil society non-state actors and another one for those who work in the business interest. This might not be an easy task because the boundaries between the two are not necessarily clear-cut. While industry associations and industry-founded research organisations can be categorised easily, industry sponsorship of patient groups, health professional associations, and public interest advocacy organisations constitutes more of a challenge.

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[62] For more information, *see*, for instance, Alden et al. 2004; Down to Earth 2004; Commercial Alert 2004.

[63] Other countries aligned with the statement were Bulgaria, Romania, Turkey, Albania, Bosnia-Herzegovina, Croatia, and the Former Yugoslav Republic of Macedonia, Serbia and Montenegro.

[64] It may also be useful to compare the Global Strategy on Diet with *WHO-UNICEF Global Strategy on Young Child and Infant Feeding* (2003) (*see*, in particular, paras 35 and 44).

Whatever the outcome of the ongoing debate about WHO's official relationships with NGOs, a better delineation between business interest and other non-state actors is indispensable to developing better safeguards in the global health arena. Such a distinction does not in any way constitute a discrimination of industry associations. The industry stand is inconsistent. Industry associations and major transnational corporations do not usually oppose being singled out as privileged 'private sector' participants in public matters and public-private partnerships. Yet, at the same time, they want to be classified as 'NGOs', 'stakeholders', 'partners' or 'constituency' when this serves their interests.

A long-standing mandate

The fact that the 2004 World Health Assembly did not adopt the new NGO policy and the accompanying resolution should not be interpreted as a signal for WHO to take no action. If it had been adopted, the resolution would have requested WHO's Director-General "to establish ... clear and specific guidelines on avoiding conflict of interest ...[and to] to institute, an external, independent review of mechanisms to safeguard WHO's integrity and independence, including the WHO's Guidelines for Interactions with Commercial Enterprises."

This would not, in fact, have given the Director-General a new mandate. It would only have reinforced an existing one to review WHO's safeguards, a mandate nearly as old as WHO's move towards partnership interactions with the commercial sector. The fulfilment of this mandate is long overdue. At the Executive Board session in January 2000, Board Members stressed the need for transparency and avoidance of conflict of interests in public-private relationships. Two years later at the Executive Board meeting in January 2002, Dr. Brundtland clarified that the *Guidelines for Interactions with the Commercial Sector to Achieve Health Outcomes* "will be updated regularly to reflect experience and will include text on recognizing and avoiding conflict of interest" and that "staff training modules on issues relating to private-sector interaction and conflict of interest are being developed" (*see* WHO 2000c; and WHO 2001).

The 'Implementation Review' section of these Guidelines states that "The application and impact of these guidelines shall be periodically reviewed." The 'Procedures for Implementation' section announces that "If appropriate, the present guidelines will be updated (for example, in the event of a change in policy or an unprecedented case)."

In the course of my interviews, concerns were expressed that, in the light of the current power constellations within the international arena, any review of the *Guidelines on Interaction with Commercial Enterprises* could lead to WHO's safeguards being weakened rather than strengthened.

Indeed, if the option favoured by the US and some key industries was adopted, a review process would probably lead to guidelines and policies that blurred still further the distinctions between the different roles, obligations and rights of business interests and other societal actors in public health matters.

If, however, the review pursued the demands expressed by other member states and public interest NGOs, the review process might well lead to a framework allowing for better guidance and management of the various types of interactions between WHO and business interest actors. The direction and outcome of such a review of public interest safeguards would depend primarily on the analytical clarity and political will of WHO's member states and its new Secretariat under Dr. Jong-wook Lee.

Any review of WHO public interest safeguards governing public-private interactions needs to yield clear guidance for WHO staff and member states on how best to assess and classify public-private interactions (including 'multi-stakeholder dialogues') and to avoid and/or manage conflicts of interest in these interactions appropriately. The review process could itself open up public debate about the value of – and potential alternatives to – the partnership model for public sector interactions with industry. The key question is how to bring about such a review.

3. Safeguard issues in the global arena

Legally independent global health alliances

A review of WHO's guidelines and policies and an opening up of the public debate are critical steps – but they would not by themselves safeguard public interests in the international health policy arena. This is partly because several policy and partnership initiatives that are beyond WHO's immediate control are having an immense impact on public health policy making and institutional structures.

These include 'global health alliances' (also known as global public-private partnerships for health or global funds) and the guidelines for interactions with the private sector issued by UNICEF and the United Nations itself.

The three most well know global health alliances today are the Global Alliance for Vaccines and Immunization (GAVI), the Global Alliance for Improved Nutrition (GAIN), and the Global Fund to Fight Aids, TB and Malaria (GFATM).

GAVI and GAIN owe their existence to multi-million dollar donations from the Bill and Melinda Gates Foundation. Microsoft founder Bill Gates and other Seattle and Silicon Valley hi-tech millionaires and billionaires adhere to the Californian venture philanthropy model. This model is characterised by active involvement of the 'charity entrepreneurs' and their foundation's staff in the activities and running of the recipient organisations or alliances. Most Californian-style venture philanthropists "demand seats on the boards, set performance goals and plan an exit strategy in case expectations are not met" (Piore 2002).[65]

These two large health alliances initiated by the Gates Foundation seem to have come with several conditionalities attached. Recipients have to agree to the private sector having decision-making power on the governing bodies of the initiative at international and national level; the money being catalyst funding for a limited period of time only; and to funds from donor and recipient countries complementing and

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[65] The key notion behind this model – that private charity should replace government spending on public services and welfare – was introduced in the 1980s by US President Ronald Reagan. Twenty years later in the UK, with the advent of "the Blairite vision … not to redistribute wealth through taxation, but to encourage business to make a profit while 'enabling' the poor to dig themselves out of the ditch," this notion is also firmly entrenched in Britain (Coote 2002). The generosity of venture philanthropists has been substantially aided and abetted by a massive restructuring of public taxation systems in recent years. To what extent can these supposedly new and untapped resources be considered as diverted tax income – money that is missing from public resources for welfare and development programmes and services?

later replacing the Gates Foundation money. Both health alliances focus on technology-driven health interventions: GAVI on vaccines, and GAIN on micronutrient provision.

The third major global health alliance, the Global Fund to Fight AIDS, TB and Malaria (also known simply as the Global Fund) was set up by the UN Secretary-General in 2001. The great majority of its funding comes from public sources. Yet the Global Fund was structured as a public-private partnership in which an industry representative has voting rights on the board, but WHO has none.

These three high-level global health initiatives are legally independent bodies whose lines of accountability are exceedingly complex.[66] WHO's member states have been side-players in their establishment and operations. A proliferation of such global health partnerships may fragment international health policy-making and programmes, and undermine WHO and national decision-making capacities. They may also divert funds away from WHO and from more holistic, less technology-centred, sector-wide approaches to health care (*see*, for example, Ollila 2003b; Zammit 2003).

Civil servants need to put in substantial time to these global health alliances in the form of technical support and advice. No estimate of what supporting these alliances actually costs WHO and its member states in terms of diverted funding and staff time has been calculated and publicised.[67] One WHO official raised concerns during our interview about the time that the current WHO Director-General had to spend on attending GAVI board meetings.

Another important type of global health 'partnership' is that between WHO and the pharmaceutical industry. Many of them, in particular some of the big drug donations programmes and access to drugs initiatives, may reflect the industry's desire to influence policy debates, particularly those on the World Trade Organisation's intellectual property agreement, TRIPS, and on drug pricing and access to drugs. One UNICEF official wondered during the course of our interview whether high-profile partnerships with pharmaceutical companies had delayed rather than improved poorer people's access to anti-retroviral drugs and other essential medicines.[68]

Three UN leaders – WHO's former Director-General, Gro Harlem Brundtland; UNICEF's Executive Director Carol Bellamy; and the UN Secretary-General Kofi Annan – have all been instrumental in launching these public-private initiatives in the

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[66] *See*, for example, Starling, Brugha et al. 2002:5–8; Heimans 2002: 16; Ollila 2003b: 48–54. For the most recent updates, *see* the websites of the respective global health alliances.

[67] This contrasts with the value placed on industry input. A study by the Initiative on Public-Private Partnerships for Health values the input of industry experts on the boards of product development alliances at US$11,000 per day in terms of 'forgone compensation' (Kettler, White et al. 2003: 14).

[68] Some interesting information in this respect can be found, for instance in Gellman 2002a; Zammit 2003: 247; Beigbeder 2004.

international health arena. Today's UN leaders could use their office to support calls for a thorough, independent and public re-evaluation of these types of arrangement so that institutions have better guidance on their impact and risks and can obtain a sounder basis for decision-making before any more high-level global health alliances are initiated.

WHO's publicly available *Guidelines for Interaction with Commercial Enterprises to Achieve Health Outcomes* do not offer much guidance as to how the Organization should deal with such large social experiment initiatives, even though GAVI was launched more than four years ago in January 2000 at the World Economic Forum (WEF). They make a cursory reference to the "establishment of multiple-party alliances" by requesting that they "should be referred to the Director-General, after due consideration by the Executive Director or Regional Director concerned and the Office of the Legal Counsel" (WHO 2000b, para 47). They do not suggest that WHO should engage in a broader consultation, for example, with its member states and relevant public interest NGOs. UNICEF's guidelines, *Building Alliances for Children: UNICEF Guidelines and Manual for Working with the Business Community – Identifying the Best Allies, Developing the Best Alliances,* do not cover global health alliances at all.

UNICEF

This publication has outlined the development public interest safeguards within WHO. Other UN agencies have also made attempts to institute public interest safeguards. The experience of UNICEF and the United Nations itself may provide further insights for those concerned about safeguarding public health.

UNICEF Executive Director Carol Bellamy cautioned in 1999:

> "It is dangerous to assume that the goals of the private sector are somehow synonymous with those of the United Nations, because most emphatically they are not. Business and industry are driven by the profit motive – as they should be and must be, both for their shareholders and their employees. The work of the United Nations, on the other hand, is driven by a set of ethical principles that sustain its mission - principles of the Charter of the United Nations, in the Universal Declaration of Human Rights, in the Convention on the Rights of the Child, and elsewhere in the galaxy of international instruments and treaties that have been promulgated since the UN's founding in 1945 [...]. In coming together with the private sector, the UN must carefully, and constantly, appraise the relationship." (Bellamy 1999)

Despite these words of caution, UNICEF's safeguards have been developed in an even less public process than that within WHO. Three years after they were issued, the agency's detailed *Guidelines and Manual for Working with the Business Community* are still not available either to the public or to collaborating public interest NGOs. A two-page executive summary is all that can be obtained upon request (UNICEF 2001b).

UNICEF executives initially explained that the full text of the Guidelines was being kept strictly internal because making them publicly available might deter commercial partners from entering into alliances with the agency. UNICEF also considered the document to be a 'business secret' (Ollila 2003c: 65; Richter 2003a).

Part of the secrecy might be because many UNICEF alliances focus on fundraising. Disclosure of UNICEF's detailed guidance on how the agency interacts with its corporate sponsors might be perceived as disclosure of a coveted fundraising tool, given the competition with other UN agencies for limited corporate funds.[69]

A more recent explanation given for UNICEF's reluctance to release its detailed Guidelines is that they are internal operational guidelines that were not drawn up with the public in mind. According to UNICEF's Director of Private Sector Division, the Guidelines are currently being revised and should be publicly available at the end of 2004.

Some UNICEF field staff, however, have felt that the secrecy surrounding the Guidelines runs counter to the democratic principle of the public's right to know. They felt that it conflicted with the general principle of transparency enshrined in the UN's *Guidelines on Cooperation between the United Nations and the Business Community* (UN 2000: paras 14, 19b). This is the route by which, eventually, a copy of the UNICEF's detailed Guidelines was made available for this research. (UNICEF 2001a)

A review of these detailed *Guidelines and Manual for Working with the Business Community* raises questions as to whether the secrecy surrounding them moreover stems from the fact that they contradict to a certain extent the Summary that had been publicly released.

The Executive Summary, for instance, strictly prohibits UNICEF from endorsing companies or products. Under the heading *No endorsement*, it categorically states that "UNICEF does not endorse any products, goods or services. At no time may any UNICEF office, staff member of UNICEF National Committee endorse or appear to endorse a company, group of companies, industry sector or third party, its products or services" (UNICEF 2001b).

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[69] Thanks to Eeva Ollila, National Research and Development Centre for Welfare and Health (STAKES), for this observation.

Yet the detailed Guidelines provide meticulous explanations on how best to place UNICEF's label on corporate products – a practice called 'co-branding' in trainings of the National Committees for UNICEF. The detailed Guidelines specify substantial financial thresholds that corporations wishing to become corporate sponsors or to engage in national, regional, and international joint fundraising alliances must reach (UNICEF, 2001a: 41–2; 26).[70]

Like WHO, UNICEF does not have an institutional definition of conflict of interest. A debate on how to bring the issue into its safeguards and policies on alliances with the business community has yet to take place. The UNICEF Executive Board seems less open to public and controversial debate than WHO's governing bodies. Yet since the Guidelines are being revised, this would be an opportune moment for UNICEF to work at seeking public comment. A more public process could help to prevent UNICEF's revised Guidelines – and the agency's future practice – from being in conflict with international policy making in the area of health and other fundamental human rights.

UNICEF has engaged in several dubious business interactions, for instance, sponsorship alliances with McDonalds and Coca Cola. These enhanced the reputation of the food industries at a time when WHO and its member states were pointing out the harmful effects of junk food and sugary drinks on children's health. These alliances also prompted questions about whether UNICEF had violated its mandate to protect, promote and fulfil children's rights.[71] Questions were raised most recently when Abbott Ross, a known violator of the International Code of Marketing of Breast-Milk Substitutes, distributed UNICEF's 2004 diary, co-branded with its company logo, to physicians in the Middle East.

United Nations Guidelines and the Global Compact

The United Nations itself issued *Guidelines on Cooperation between the United Nations and the Business Community* in July 2000. A primary aim of these Guidelines was to foster policy coherence within the UN. Like the WHO Guidelines, these UN Guidelines are available on the UN website.[72]

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[70] Questions have been raised about the degree to which UNICEF's liberal exchange of its logo for corporate funds, particularly its minimum recommended financial thresholds of US$100,000 for National Alliances, US$250,000 for Cross-Border Alliances, and US$500,000 for International Alliances, "stretch the limits of jurisprudence". For more details, *see* Tesner with Kell 2000: 79–81.

[71] *See,* for instance, Zammit 2004: 61; Richter 2003a: 9.

[72] www.un.org/partners/business/otherpages/guide

The UN Guidelines stress that the Secretary-General's Global Compact (a high-level policy partnership between business community, the UN and other 'stakeholders') provides the overall framework for co-operation with the business community. They advise UN organisations to use the Global Compact's nine universally-accepted principles from the fields of human rights, labour and environment as reference points in their co-operation with the business community and they encourage them to add additional criteria specific to their mission or mandate (UN 2000, para 12).[73] Consequently, these nine criteria have entered into the corporate screening procedures of many UN agencies, including WHO.

The Global Compact Office itself, however, does not assess corporations according to these criteria before accepting them as Global Compact participants,[74] a fact that does not seem to be common knowledge within other UN agencies. Interviews and statements by staff in other UN agencies suggest that many of them assume that the companies participating in the Global Compact have been screened for their responsible corporate behaviour and are thus acceptable partners requiring no further assessment.

This assumption may create further confusion in the future. It may also impinge on the ability of international civil servants to refuse a joint project proposed with a Global Compact corporate participant. One official in WHO's Government and Private Sector Relations Division, for example, refused to approve a joint project because evaluation of the company's proposed arrangement suggested corporate motives that clearly contradicted WHO's guidelines. His judgement was, at first, challenged on the grounds that the corporation in question was a Global Compact participant. Further developments proved his decision well founded.

The fact that the Global Compact does not scrutinize the actual practices of its participant companies, yet still presents them as leading 'corporate citizens' has another impact in the field of health (and in other social areas.) It provides companies with a good image. Such an enhanced reputation can act as a shield or 'goodwill bonus' against the efforts of UN agencies, member states, citizen watchdogs and labour groups to hold them accountable to the public for their actions, either through regulation or through public naming-and-shaming.

The Global Compact's acceptance of the infant food manufacturer, Nestlé, is a case in point. The company is well known for persistently violating the International Code of Marketing of Breast-milk Substitutes and subsequent related WHA resolutions and for attempting to undermine its national implementation.[75] According to UNICEF's

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[73] In June 2004, corruption was added as tenth criterion

[74] For details of the approval process, *see*, for example, Zammit 2003: 79. For the latest acceptance conditions, *see* the Global Compact's website: www.unglobalcompact.org.

[75] *See, for instance,* IBFAN/ICDC 2004; Richter 2001.

corporate screening criteria, Nestlé is not eligible for alliances with the agency because of these practices. Yet the Global Compact not only accepted Nestlé's participation, but also singled out and praised its socially responsible labour practices. Global Compact Executive Head Georg Kell dismissed concerns about the negative impact that Nestlé's acceptance could be predicted to have on work to prevent harm to children's health and lives. He described such concerns as a 'single-issue' in contrast to the Global Compact's much broader aims (Richter 2003b: 44–45).

These few examples show that safeguarding public interests in the field of health needs a more thorough examination of the guidelines and actual procedures of other UN agencies besides those of WHO. It also requires a thorough evaluation of legally independent global public-private partnerships. An investigation should examine whether restructuring the decision-making arrangements of these social experiment initiatives or abandoning them altogether may, in fact, be the best way to safeguard public interests and to preserve the integrity of scientific and democratic processes.

4. Building safeguards for public-private interactions: The wider context

The major obstacle to clarifying and instituting public interest safeguards seems to be political rather than theoretical or technical. It is unlikely, therefore, that meaningful and effective safeguards can be fostered unless the frameworks of thought that have favoured the emergence and continued dominance of the public-private 'partnership' policy paradigm in the international health arena, and the push and pull factors that have supported them, are taken into account.

The rise of the partnership paradigm within the UN

Five factors

Five major intersecting factors emerge from the histories of public-private 'partnerships' involving the UN and WHO:[76]

1. Financial pressures on the UN, its agencies and programmes;
2. A shift of the dominant development model from that of the New International Economic Order (NIEO) to Washington consensus-based models;[77]
3. UN leaders who favoured the neo-liberal restructuring of the UN;
4. Major transnational corporations recognising that collaborating with the UN could help them gain markets and political influence and could ward off pressure from UN member states and social movements critical of an 'unfair globalisation'; and
5. Hopes raised by some large-scale private donations, in particular by the venture philanthropy donations of media magnate Ted Turner and Microsoft founder Bill Gates.

The 1992 Rio de Janeiro Earth Summit

The beginning of the UN trend towards closer policy relationships with big business is often set at 1992 when the UN held its Conference on the Environment and

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[76] *See*, for instance, Tesner with Kell 2000; Bruno and Karliner 2002; Zammit 2003: 28–36; Buse and Walt 2000a; Buse and Walt 2002b

[77] For more information on these models, *see*, for instance, Emmerij et al. 2001.

Development (UNCED), dubbed the 'Earth Summit', in Rio de Janeiro.[78] Until then, transnational corporations and their business associations had often taken a stand against the work of UN agencies. Their stand had been particularly pronounced in the 1970s and early 1980s when UN agencies were striving to fulfil their mandate to work for redistributive social justice policies under the New International Economic Order framework. This mandate included drawing up a UN Code of Conduct for transnational corporations and advocating the transfer of resources and technology from North to South.

In 1992, however, a few years after developing countries had lost the little influence they had in international politics because of geopolitical changes following the end of the Cold War and the effects of the debt crisis, work on this UN Code was abandoned. Author Sandrine Tesner describes the UN's abandoning this Code, even though negotiations had resulted in a text such that adoption was within reach, as an attempt to quell any lingering private sector "suspicion" about the organisation because of its work towards a New International Economic Order (Tesner with Kell 2000: 22-23).

The demise of the UN Code came shortly after influential business associations such as the International Chamber of Commerce (ICC) and the newly formed World Business Council for Sustainable Development (WBCSD) had mounted a massive publicity campaign at the Earth Summit. A WBCSD publication, *Changing Course,* set the tone. It presented the combination of free markets, free flows of foreign direct investment and 'voluntary' corporate social responsibility as the best way to achieve sustainable development. Public, binding regulation of corporate practices was presented as anti-industry and a needless waste of public resources (Bruno and Karliner 2002: 22–32).

Resistance against regulation of transnational business

This industry strategy was nothing new. WHO, like other UN agencies, had often had to withstand pressure from industry and from its major financial contributor, the United States, whenever it proposed regulating products or practices of transnational corporations that were harmful for health. In 1981, for instance, the World Health

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[78] For example, a report by the UN's Joint Inspection Unit marks the Earth Summit as a "turning point" in "bringing the private sector into policy formation." The Agenda 21 resulting from the Earth Summit introduced a new form of UN interlocutors, nine Major Groups, which included business as a category. The report of the UN's Joint Inspection Unit notes that the Commission on Sustainable Development experimented with a new form of participation, "multi-stakeholder dialogues," to allow business and industry (on a par with other societal actors) to contribute to strategies and policies for sustainable development (Mezzalama and Ouedraogo 1999: 12).

Assembly had adopted the International Code of Marketing of Breast-milk Substitutes. The International Federation of Pharmaceutical Manufacturers Associations (IFPMA) (some of whose members were also infant food manufacturers) regarded this code as the result of tactical mistakes. They vowed to make sure that there was no similar international regulation of transnational pharmaceutical practices. Their efforts included enlisting the support of industrial countries against what they depicted as the illegitimate attempts of WHO to act as a 'supranational' regulatory body.[79] In the mid-1980s, the US State Department emphasized its:

> "strong position that the World Health Organization should not be involved in efforts to regulate or control the commercial practices of private industry, even when the products may relate to concerns about health. This is our view regarding infant food products, and pharmaceuticals, and tobacco and alcohol." (quoted in Chetley 1990: 92)

In 1986 and 1987, when WHO tried to produce some Ethical Criteria for Medicinal Drug Promotion, the United States withheld a large part of its contribution to the Organization. The US started paying some of its arrears only after an 1988 editorial in *Science*, an influential international journal, pointed out that it was unfair to withhold $118 million, nearly one-quarter of WHO's budget, when one of WHO's achievements – the eradication of smallpox – saved the United States $110 million in vaccination costs each year (Chetley 1990: 120–1).

The United Nations faced a similar situation. Even though it had gradually been moving away from ideas underpinning the New International Economic Order since the 1980s and even though it had come to accept business as a regular interlocutor, for example, in its Commission of Sustainable Development, the UN continued to be subject to depictions promulgated by conservative think-tanks as being an anti free market, inefficient and expensive organization. In 1997, it was brought to the brink of bankruptcy because the US deliberately withheld $1.5 billion in contributions in order to bring about reforms within the UN.[80]

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[79] *See* Richter 2001: 92–94; Chetley 1990: 69–93.

[80] For more information, *see* Zammit 2003: 41–47. The total 1996 UN budget contribution from the US, including assessed and voluntary contributions, of US$ 4.5 billon amounted to less than the combined costs of New York City's Fire and Police Department (South Centre 1997).

Reform of the United Nations

These long-standing pressures on the United Nations combined with the election of Kofi Annan as the new UN Secretary-General in December 1996 led to the institutionalisation of the 'partnership with industry' model within the UN system as part of Annan's UN reform. As a 1999 report by the UN's Joint Inspection Unit put it, "the strong leadership of the Secretary-General ... and his expressed conviction that the goals of the United Nations and the private sector can be mutually supportive has given additional momentum to a rapprochement made necessary by changes in the global environment" (Mezzalama and Ouedraogo 1999: 5).

Several commentators regard 1997 as the 'turning point' of UN-business relations. It was in July of that year that Annan:

> "unveiled a long-awaited reform proposal that was the result of a team headed by Maurice Strong . . . former CEO of several large corporations, who had headed the preparations of the Rio Conference a few years earlier. While the report did not devote a specific section to the UN-business relationships, it emphasized the role of civil society as not only a disseminator of information or provider of services but also as a shaper of policy. Civil society referred to nongovernmental organisations, academic and research institutions, parliamentarians, and corporations. Indeed the report stated openly that the relationship of the UN system with the business community was 'of particular importance'." (Tesner with Kell 2000: 33)[81]

A few months later, in January 1998, the UN Secretary-General delivered a speech at the World Economic Forum (WEF) in Davos, Switzerland, where he spoke about a "fundamental shift" within the United Nations. He said that the UN recognized that peace and prosperity could not be achieved without 'partnerships' between various sectors in society, including business. He added that while the UN and business community were "still overcoming a legacy of suspicion" of each other, they could "bridge these differences and turn what had been fledging arrangements of cooperation into an even stronger force" (quoted in Mezzalama and Ouedraogo 1999: 5).

High hopes that the new partnership paradigm would replenish the UN's financial coffers were raised in September 1997, when Time Warner vice-chair and CNN founder Ted Turner donated US$1 billion to the UN via his new philanthropic UN Foundation – even though the private sector immediately indicated that they did not want to see partnership with the UN primarily in terms of donating funds (Tesner with Kell, 2000: 35; 89).

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[81] This statement exemplifies confused terminology as well as the privileged status of the private sector.

Talks with industry

Regular attendance of UN leaders at the annual World Economic Forum and other business fora has been a feature of the new partnership paradigm ever since.

Talks between the UN Secretary-General, UN senior staff and leaders of the International Chamber of Commerce have led to several statements outlining the potential for the goals of the UN and of business to be mutually supportive. These statements emphasized how the UN can give business a greater role in setting global rules and thereby create 'win-win' situations, or what the Secretary-General later called a 'globalisation with a human face'.[82]

In September 1998, for instance, the International Chamber of Commerce (ICC) held a Business Roundtable Dialogue in Geneva, a continuation of talks initiated by Kofi Annan in 1997. It brought together Chief Executive Officers (CEOs) of 450 companies, and leading figures from UN agencies, the World Trade Organization and the World Bank. According to Helmut Maucher, then ICC president and Nestlé CEO, the Geneva dialogue was convened in order "to bring together the heads of international companies and international organizations, so that business experience and expertise is channelled into the decision making process for the global economy" (quoted in Balanyá, Doherty et al. 2000: 167).

The visible outcome for those who had not been invited to this closed meeting was the *Geneva Business Declaration*, which indicates how industry saw the role in global decision-making not only of business but also of other societal actors. For example, it advocated attributing 'additional authority' to intergovernmental organizations but only "with the proviso that they must pay closer attention to the contribution of business and competition to wealth creation [and] recognize the need for less bureaucracy". 'Lean' and 'strong' governments should reshape rules in ways that promote transnational business and flow of finances. Industry leaders warned governments, however, not to confuse 'strong' with "economic nationalism" because this would be "out of step with the realities of the global economy" (ICC 1998).[83]

The *Geneva Business Declaration* also outlined how a "diffuse but virulent globophobia" should be "opposed" by improving citizen understanding of globalisation and its impact. ICC member companies accepted that citizens may voice their concerns about the uncertainties created by economic globalisation, but their *Declaration* sowed

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[82] For some of the important early policy discussions at the World Economic Forum and in discussions with the ICC, *see*, for example, Tesner with Kell 2000: 31–37. For a more critical account, *see*, for instance, "The corporate cooptation of the United Nations" *in* Balanyá, Doherty et al. 2000: 166–174.

[83] Points 5.1. and 6.4.

the seeds of distrust towards "activist pressures groups". Their emergence, it claimed, "risks weakening the effectiveness of public rules, legitimate institutions and democratic processes." The business leaders suggested establishing rules defining the 'rights' and 'responsibilities' of 'activist' groups if they did not take steps to improve internal democracy, transparency and accountability (ICC 1998).[84]

Business interest in UN partnerships

The beginnings of the UN-business partnership paradigm not only coincide with a severe funding crisis within the UN but also with growing industry concerns about financial instability triggered by the collapse of the Mexican economy in 1994 and then by financial crises in several Asian countries in 1997. Business leaders concluded from these shocks that wholly unregulated markets were not, in fact, good for international business and finance. In the words of the *Geneva Business Declaration,* "a key challenge in the context of a rules-based freedom for business is to prevent financial meltdowns and maintain a stable international financial system."[85] Moreover, in the late 1990s, corporations were growing increasingly concerned about the resistance of some states and citizen movements to global neo-liberal restructuring. Several of them had worked against the proposed Multilateral Agreement of Investment (MAI) that would have given rights to transnational corporations equal to and even above those of nation states. A focus of this resistance was to prevent the extension of unfair global trade agreements, resistance that became most visible at the World Trade Organization's bi-annual Ministerial Meeting in Seattle, USA, at the end of 1999.

Against this backdrop, an arrangement seems to have been reached between the UN and big business. If UN leaders tried to reshape their organisations in ways conducive to a business friendly climate, to involve business leaders still further in global policy debates, and to help them deal with activist movements and organisations, then business associations would help to turn back the tide of sentiment against the UN within the business community and relevant government circles, particularly in the United States. This agreement is reflected in the Global Compact, which is often presented as the flagship UN-business partnership, a kind of 'social contract' that will safeguard and promote both public and private interests in a globalising world.

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[84] Points 4.1 and 6.3 and conclusion 4.

[85] Point 4.3.

The Global Compact

The Global Compact was first presented by UN Secretary-General Kofi Annan in January 1999 at the World Economic Forum in Davos, Switzerland. He challenged companies to integrate nine universally accepted principles from the fields of human rights, labour rights and environmental protection into their business practices. In return, UN organisations would work for open global markets and help companies 'dialogue' with their critics (Annan 1999).

Although the arrangement has since been formalized under a Global Compact Office, there are still no meaningful Global Compact internal mechanisms for assessing whether the participating companies engage in harmful practices. The anticipated social benefits derived from what was assumed to be a noticeable improvement in corporate practices by their adherence to the nine selected ethical principles remain unproven.[86]

For the corporations involved, however, the Global Compact arrangement has arguably brought great benefits. It can be seen as one of the most cost-effective ways of improving tarnished corporate images by what has been termed 'bluewashing' – image transfer by being associated with the UN flag.[87] The Global Compact has lent itself to corporate undermining of more comprehensive and possibly binding international human rights regulation of transnational corporations because corporations now argue that such regulation goes against the spirit of the Secretary-General's 'voluntary' Global Compact.[88] [89] The Global Compact helps to increase the influence and spread of

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[86] In 2002, UNRISD project coordinator Peter Utting concluded in his review of regulation via 'multi-stakeholder initiatives' that "the Global Compact still needs to prove its ability to force the pace of corporate reform" (Utting 2002: 90). Recently, the Global Compact Office commissioned a review of the Global Compact's impact from the business consultancy firm, McKinsey&Company, in preparation for the Global Compact Leaders' Summit in June 2004. This review did not assess the impact of participation in the Global Compact on the corporations' actual business practices in the areas of the nine Global Compact principles. For more information on the review's findings, for example, why companies regard the Global Compact as an "entry-point to accessing the broader UN system" and why it could come to "symbolize a powerful example of the potential of UN reform", *see* McKinsey&Company 2004.

[87] Term coined in Bruno and Karliner 2000.

[88] For example, the International Chamber of Commerce (ICC) and the International Organization of Employers (IOE) have expressed their opposition to the 'binding and legalistic approach' of the UN Draft Norms on the Responsibilities of Transnational Corporations and other Business Enterprises with Regard to Human Rights. They have described efforts towards more public international regulation of transnational corporate practices as "counterproductive to the UN's ongoing efforts to encourage companies to support and observe human rights norms by participating in the Global Compact." They have said that the draft norms "risk inviting negative reaction from business, at a time when companies

transnational corporations through fostering national mini-Global Compacts and various partnership projects. It has also helped to draw distinctions between 'radical fringe elements' of civil society (also termed 'sharks' and 'orcas') and those NGOs of the 21st century that use market mechanisms to work for change (Sustainability 2003: 14; 50). It contributes to marginalising those advocacy groups and networks that are critical of the Global Compact and other partnership arrangements that they regard as inappropriately close relationships between public interest and commercial actors.[90]

The Global Compact can also be seen as an arrangement that marginalises the wishes of many UN member states. The Global Compact was not initiated as a result of a mandate from UN member states.[91] In fact, when the UN Secretary-General announced that he wanted to establish more formal consultations mechanisms between the UN and business by creating a United Nations Enterprise Liaison Office, modelled along the existing Non-Governmental Liaison Office, member states opposed the proposal because they perceived it as a challenge to their sovereignty in policy-making (Tesner with Kell 2000: 33).

UN member states hesitantly approved the Global Compact initiative only after it had already been set up by the UN Secretary-General. But they qualified their approval with the condition that the Global Compact should be not be regarded as a permanent arrangement and that it should be formally evaluated some time later (Zammit 2003: 48).

The Report of the Secretary-General to the UN General Assembly in 2001, which was instrumental in gaining more support from the UN member states for the Global Compact, states: "to avoid potential conflicts of interest, the Global Compact does not accept financial contributions from the private sector for its own operations" (UN 2001: 33).

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are increasingly engaging into voluntary initiatives to promote responsible business conduct" (ICC/IOE 2003).

89 Early on, the International Chamber of Commerce (ICC) had laid out its prime condition for participating in the arrangement: "There must be no suggestion of hedging the Global Compact with formal prescriptive rules. We would resist any tendency for this to happen" (ICC 2000). While opposing binding regulation for potentially harmful corporate practices, the ICC was very much in favour of binding and enforceable rules in other areas. When it signalled its support for the Global Compact, it specified that, in return, the UN's September 2000 Millenium Assembly should "ensure that the United Nations takes the lead in supporting a rules-based open system of international trade and investment while opposing all forms of protectionism" (quoted in New 2000).

90 For more information, *see*, for example, Zammit 2003: 29–104. For an account how the Global Compact contributes to creating these distinctions in the NGO community, *see* pp.80–81.

91 For more information about the partnership paradigm being institutionalised before any discussion with UN member states, *see*, for example, Ollila 2003c.

The Global Compact Office seems to interpret this statement very loosely. To replicate the Global Compact by setting up national, regional or industry-sector specific Global Compact networks, the Global Compact website, under the heading 'outreach events', gives the following advice: "Companies and other donors can be asked to contribute to the costs of the outreach event" (UN 2003d). Once in place, running such a network should not be difficult, because the website suggests putting in place "a small secretariat funded by contributions of the network participants" (UN 2003c). An example of this is the Symposium on the United Nations Global Compact and Swiss Business, held in Switzerland in October 2002. The event was a Nestlé co-funded launch of the Global Compact network in Switzerland and promoted Nestlé as a socially responsible employer.[92]

Moreover, the Global Compact Office seems not to have seen any conflict between its mandate and soliciting corporate funds for its *The 21st Century NGO* report and its Executive Head promoting the publication as the Global Compact's contribution to the "high-level UN panel that is currently examining the interaction between civil society and the UN system as a whole".[93]

The rise of the partnership paradigm within WHO

A similar pattern can be seen in the international health arena. WHO's regular budget has been frozen since the early 1980s and member states' assessed contributions have declined despite the growing number of tasks facing the Organization.[94]

Strong support from above

A key factor in the exponential increase in WHO's promotion of and involvement in public-private partnerships was the election of Gro Harlem Brundtland in May 1998 as WHO Director-General. Dr. Brundtland had been a strong supporter of partnership models ever since she had chaired the World Commission of Environment and Development whose recommendations catalysed the 1992 Earth Summit. Back in 1990, she had asserted:

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[92] For more information, *see* Richter 2003b: 44–45.

[93] The main corporate funders were Novo Nordisk, VanCity Savings Credit Union, Du Pont, Holcim and the International Finance Corporation (Sustainability et al. 2003: 2).

[94] *See* Box 2: 'How donors call the shots', *in* Yamey 2002b: 1108. *See also* DFID 2002: 18; Ollila 2003c: 46.

> "Partnership is what is needed in today's world, partnership between government and industry, between producers and consumers, between the present and the future . . . We need to build new coalitions . . . We must agree on a global agenda for the management of change . . . We must continue to move from confrontation, through dialogue to cooperation . . . Collective management of the global interdependence is ... the only acceptable formula in the world of the 1990s." (quoted in Lohmann 1990: 82)

As Prime Minister of Norway in the 1980s and 1990s, Dr. Brundtland had been a promoter of Third Way politics. Immediately after her election as the WHO Director-General, she began reshaping the agency along neoliberal lines reflecting the modified Washington Consensus (with a human face) model[95] and the Third Way thinking exemplified by British Prime Minister Tony Blair's New Labour party.

As Buse and Walt point out, the characterising feature of the UK Third Way model is a form of "neocorporatism" in which a variety of social actors, including the private sector, are regarded as 'stakeholders', all of whom are believed to have a legitimate say in public policy making (Buse and Walt 2000b: 551).[96] This corporatist view is also

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[95] The term Washington Consensus was coined by John Williamson, a senior fellow at the Institute for International Economics and former World Bank staff member in 1993. It refers to one type of neoliberal economic thinking which was elaborated in Washington, the site of the Bretton Woods institutions (the International Monetary Fund and the World Bank), the US government, and conservative think tanks. It's prescriptions, known under the name structural adjustment policies, shaped development policy in the 1980s and 1990s. A book on the history of ideas in the UN describes this first Washington Consensus as "a recycled version of trickle-down economics, with growth given greater weight than income distribution and social objectives. The underlying hypothesis was that policy reforms designed to achieve efficiency and growth would also promote better living standards, especially for the poorest. The social costs were [seen as] inconvenient and temporary." It was only after resistance of many developing countries and publication of UNICEF's *Adjustment with a Human Face* (Giovanni et al. 1987) that these policy prescriptions changed. UNICEF's study argued that these social costs were not just unfortunate but inevitable by-products of structural adjustment but that they could and should be avoided by putting people, and in particular vulnerable groups in a country's population, at the center of attention. (for more information, *see* Emereij et al. 2001: 128–130) The Washington consensus II took some of these concerns on board, for example, when advising to "invest" in health and education. Yet, it remains a fundamental problem that Washington Consensus models continue to dominate development thinking and policies and that they, more than ever, promote social engineering, for example by advocating corporatist models of decision-making. Better alternatives are not given enough space neither in debate nor in practice (*See also* Bøas and McNeill 2004: 224, fn. 9).

[96] Buse and Walt point out that, as early as 1987, author G. Peters had described the corporatist nature of what they call Global Public Private Partnerships as a form of third party government. *See* Buse and Walt 2000b: 551.

inherent in the global governance model that has made its way from the Bretton Woods institutions (World Bank and the International Monetary Fund) into UN politics.[97] Its philosophy is 'shared decision-making', which is at the core of the UN's 'partnerships' with industry. Its actual arrangements include financial relationships, joint operational ventures, and policy interactions such as agenda-setting 'multi-stakeholder dialogues' and roundtable discussions.

A new Corporate Strategy for WHO

In January 2000, Dr. Brundtland presented a new *Corporate Strategy for the WHO Secretariat* to WHO's Executive Board. This document emphasized the need to increase the effectiveness of WHO's work through "collective action and partnerships". The corporate strategy defined the new task of the Secretariat's work as decreasing inequities in health by "carefully negotiating partnerships and catalysing action on the part of others." It made "negotiating and sustaining national and global partnerships" into a 'core function' of the WHO Secretariat (WHO 1999a, para 5, 9, 15).

The document stressed that this emphasis should not be regarded as constituting a change in WHO's mission as set out in its Constitution, and that the Secretariat's new corporate strategy would continue "to reflect the values and principles articulated in the Global Strategy for Health for All and reaffirmed by the 1998 World Health Assembly" (WHO 1999a, para 8).

Shift away from Health for All

But many observers disagreed, saying that WHO was shifting away from its constitutional mandate and from an approach informed by human rights and social justice. As the roadmap for guiding WHO policy, Dr. Brundtland chose the World Bank's 1993 annual World Development Report, *Investing in Health,* which advised governments to focus on cost-effective interventions rather than on strengthening health care systems. Many of the Report's authors were brought to WHO to establish a new Evidence and Information for Policy unit. WHO, said one public health academic, became "a branch of Harvard and the World Bank" (quoted in Yamey 2002b: 1110).

In the year 2000, there was no official reflection within WHO on the obstacles that had stood in the way of achieving Health for All since the goal and strategy had

[97] *See*, for example, Buse and Walt 2000b: 554. For a critique of neoliberal governance, *see*, for example, Taylor 2004.

been announced by WHO and UNICEF in 1978. Nor was there any reflection on how to continue on the path as reaffirmed by member states in 1998. On the contrary, according to one WHO official, Health for All was "censored" from WHO's headquarters language (quoted in Yamey 2002c: 1172).[98] Some observers remark that if it had not been for the Peoples' Health Movement, founded in 1999, Health for All may well have disappeared from the international public health agenda.

In January 2000, Dr. Brundtland established a Commission on Macroeconomics and Health (CMH) and charged it with assessing the place of health in global economic development. Several national governments and the private foundations of Bill and Melinda Gates, and Ted Turner paid for its work. In December 2001, the Commission presented its report *Macroeconomics and Health: Investing in Health for Economic Development* (which has become known as the Sachs Report after the Commission's chair, economist Jeffrey Sachs). WHO's Director-General translated it into a blueprint for international health strategies (CMH 2001).

The Commission stated that one of its main achievements had been to turn around the relationship between economic development and health. It still mentions that people's health is a "priority goal in its own right," but emphasises the notion of "health as a central input into economic development and poverty reduction" (CMH 2001).

The report stresses the benefits of what it described as new funding mechanisms, namely the newly established Global Fund to Fight AIDS, Tuberculosis and Malaria and other funds modelled along the lines of the GAVI alliance. It also called on the pharmaceutical industry to "generalize the corporate principles" that were seen as the basis of "highly laudable programs of drug donations and price discounts." It promoted the international pharmaceutical industry as a key player in voluntary and cooperative arrangements with governments, donors and international organizations that would enable poorer people to gain access to essential medicines "while protecting intellectual property rights to the maximum extent"[99] (*See*, for example, CMH 2001:19 goal 7; and 14–15; 86–91).

The Commission recommended that WHO become the technical secretariat for the Global Fund and dismissed WHO member states' concerns about conflicts of

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[98] Health for All had become an "unfashionable, if not 'dirty word' in the 1990s," says Kent Buse. "Health for All was tied up with a political battle for equity and inclusion. In the 90's health policy came to reflect the prevailing ideology. An ideology which emphasized health systems reform – a market oriented approach informed by economic tools and neoliberal values" (Yamey 2002c: 1172). For more details, *see also* Ollila 2003a: 138–145.

[99] Interestingly, patient and other action groups that have been instrumental in lobbying for lower priced anti-retroviral drugs are not mentioned as indispensable partners in the alliances envisioned by the Commission.

interest in what the Commission presented as 'more flexible working approaches' (that often include the private sector in decision-making positions on boards of the new global health partnerships) as unnecessary constraints.

Soon after the Commission's report was released, several articles in medical journals and the general media expressed grave concerns about the proposed changes in the international health arena. A lead article in *Le Monde Diplomatique* asked whether Dr. Brundtland was promoting 'Health for All or Riches for Some?' It queried how Dr. Brundtland could have endorsed drug patents in a speech at the World Economic Forum in January 2001 when lower-income countries were still battling for access to affordable antiretroviral drugs in the face of the WTO's TRIPS agreement. Such endorsement, it argued, could not be seen as support for countries such as South Africa, which five weeks later was faced with a law suit from 40 major pharmaceutical TNCs challenging the government's proposed legislation to allow generic drugs to be imported from other countries. The article expressed apprehension at WHO's increasing dependency on sponsors who could establish the rules of the game (Motchane 2002).

The editor of the respected and prestigious medical journal, *The Lancet*, Richard Horton, initially indicated satisfaction with the high-profile promotion of the Sachs report because he thought that the shift in policy approach advocated by the report might attract more funding into the health arena. At the same time, however, Horton's editorial drew attention to problems caused by WHO's proximity to certain industries. He contrasted Dr. Brundtland's relative silence on the social responsibilities and problematic behaviour of pharmaceutical companies with her forceful public condemnation of tobacco companies. He also highlighted the climate of censorship developing within WHO and the Organization's lack of openness to discussing differing views and opinions about the changes and their impacts that the new management had brought in (Horton 2002a: 1607).

A few months later, in September 2002, Horton raised the alarm when the UK, WHO's third largest extra-budgetary government donor, asked WHO to make its "roles and mandates … consistent with the [UN's] Millennium Development Goals." The request was an implicit demand that WHO refocus its activities towards supporting the Global Fund and the UN Millenium Task Force on AIDS, malaria, tuberculosis and access to essential drugs. *The Lance*t pointed out that such a shift could lead to WHO neglecting other areas of its mission, such as supporting the development of comprehensive health programmes and setting international norms and regulatory standards. Horton concluded that the UK's demand could well lead to a "damaging reinterpretation" of WHO's mandate (Horton 2002b).

By this time, it was clear that private sector donations were increasingly regarded as important in the international health arena. When the Bill and Melinda Gates Foundation donated US$750 million to set up the Global Alliance for Vaccines and

Immunization (GAVI) in 1999, hopes soared of greater access to previously untapped financial resources. Hopes were also raised when several major pharmaceutical companies made high-profile drug donations and offered to reduce the prices of selected pharmaceuticals.

No alternatives to partnerships with business?

A year before Dr. Brundtland stepped down from the post of WHO Director-General in 2003, she reportedly indicated unease about legally independent global health alliances in the context of WHO's difficulties in ensuring its accountability to its member states (Yamey 2002a, Buse 2002). Yet, at the same time, she continued to tell member states that:

> "In a world filled with complex health problems, WHO cannot solve them alone. Governments cannot solve them alone. Nongovernmental organizations, the private sector and Foundations cannot solve them alone. Only through new and innovative partnerships can we make a difference. And the evidence shows we are. *Whether we like it or not, we are dependent on the partners* ... to bridge the gap and achieve health for all." (Brundtland 2002a, emphasis added)

This assertion reinforced the impression that partnerships *per se* are part of well proven, inherently positive, even unavoidable, policy model. But, as stated earlier, subsuming such a range of interactions between public and private sector actors under the one umbrella term 'partnership' obscures the fact that many of these interactions are not fundamentally new. Re-naming all kinds of financial, policy and operational relationships and collaborations as 'partnerships' hinders decision-makers and civil servants from calling upon the hard-won knowledge and experience gained over many years about which interactions are likely to be relatively unproblematic, which are unproblematic as long as they are appropriately circumscribed, and which should be not be pursued under any circumstances.

There is a need to recover more systematically this existing knowledge on public-private interactions and to adapt and use it when assessing the various global public-private interactions in the international health field. There is a need to probe deeper into the added value, risks and costs of the newer 'social experiment' UN-partnerships. Above all, there is a need to examine the extent to which promoting the 'partnership-with-the private sector' paradigm conflicts with the core values and functions of WHO and other UN agencies.

Alternatives

The partnership paradigm is not a given, but is a result of a particular framework of thought and constellation of power. Political choices about the future course of the UN's approach to interacting with business actors can and have to be made.

One alternative to the PPP model is based on looking at the issues in a different way. It is based on the premise that the public and the private sector have different mandates and roles. The following measures can help WHO to ensure due diligence in these interactions:

- re-name public-private partnerships as public-private interactions or initiatives (PPIs) or similar, less value-laden terms;
- identify the category and sub-categories[100] of the interaction that best facilitates identification of risks and conflicts of interest; and
- establish clear and effective institutional policies and measures that put the public interest at the centre of all public-private interactions.

One of the prime conditions for developing better institutional policies on these public-private interactions is to abandon the culture of censorship within WHO that currently stifles debate on pros and cons of closer collaboration with the private sector, the adequacy of existing safeguards, and the links between neoliberal economic ideology and the worldwide restructuring of public institutions and policies.[101]

WHO today

Is a candid review of WHO's approach to public-private 'partnerships' possible under the Organization's new leadership of Dr. Jong-wook Lee? When the *British Medical Journal* interviewed all the candidates for WHO's top job in early 2003, Dr. Lee said he would be a "listening" Director-General. As a former director of WHO's 'Stop TB' programme, he favoured cross-sectoral interactions. At the same time, he remarked that public-private partnerships were a means, not an end in themselves. He recognized the risk that groups with vested interests may want to use partnerships to skew WHO's normative functions and pointed to the need to elaborate clear rules to prevent this from happening (Lee 2003).

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[100] Such as category: funding relationships, sub-category: drug donations. The Guidelines for Interaction with Commercial Enterprises contain already a good guidance for certain categories.

[101] Medical journalist Gavin Yamey advocated an open appraisal of global public-private partnerships and the establishment of a sound WHO policy "that has come from a process of open discussion and debate" (Yamey 2002a).

The *World Health Report 2003* outlined the new administration's views and plans for the future and emphasised the need to build a global health partnership. It states emphatically that such a partnership must be based "not only on rigorous science but also *on a clear ethical vision*".

The *Report* reminds readers about the need to link partnership building to core values underlying an overall ethical vision of public health. Specifically mentioned is the WHO Constitution and the fact that it defined back in 1946 "the enjoyment of the highest attainable standard of health" as a fundamental human right. This *World Health Report* reiterates the close connection between health – understood as a "state of complete physical, mental and social wellbeing" – and social justice, peace and security. At the same time, however, the Report refers to the centrality of the Millenium Development Goals in WHO's agenda and indicates that WHO regards health as both "a goal in itself and a key development input towards other goals" (all quotes WHO 2003a: xiii, emphasis added).

Since Dr. Lee took office in July 2003, there is some indication that WHO has started refocusing its work around the principles of Health for All. But as far as updating and strengthening public interest safeguards in public private interactions is concerned, interviews with UN officials indicate that this task has not figured among the new Director-General's priorities during his first year in office. In fact, disquiet was expressed over the reduction of financial resources and staff working on these issues.

Establishing a clear institutional policy on public-private interactions and giving guidance for WHO and member states officials on how to manage these interactions appropriately is a complex and politically sensitive task. Yet the new WHO leadership needs to face up to the challenge without delay in the interest of the health of the peoples of this world.

5. Conclusion: The tasks ahead

Since the late 1990s, the number and reach of global public-private interactions have increased dramatically. Many of these interactions have been conducted under a new framework of thought that turns the UN, governments, the commercial sector, and other societal actors into 'partners' and regards 'shared decision-making' as a core component of the interaction.

WHO has been forcefully promoting the public-private partnership paradigm since 1998. Have public interest safeguards in the international health policy arena kept pace with this policy development? This study has focused on WHO as the UN's designated specialised agency for global health matters. It has also looked at safeguards within a few other UN agencies to ascertain whether there is policy coherency among the various UN agencies, funds and programmes to protect their general and specific mandates and functions.

This study concludes that international civil servants, member states and NGOs have been encouraged to engage more and more in interactions with commercial actors, but the development of accompanying public interest safeguards has lagged far behind and is nowhere near completion. One of the greatest challenges is to clarify the ethical framework underlying intergovernmental agencies' interactions with the private sector.

WHO's delay in doing so can be explained by both political and theoretical factors. Simply raising issues of conflicts of interest has often been regarded as an obstacle, rather than an indispensable part of a complementary system of checks and balances.

A lack of openness to discussing the tensions and ambiguities between WHO's mandate and its partnership paradigm has contributed to the delay. In the late 1990s, UN agencies were instructed to 'mainstream' human rights in their work as part of the UN reform. At WHO, however, this work has not really happened. Since the Commission on Macroeconomic and Health's report, there has been a steady shift from a human rights-centred approach to one that instrumentalises people's health for economic ends. WHO is currently considering whether to upgrade its conceptual work on the links between health and broad human rights (Leitner 2004).

All these developments have undermined the ability of WHO and its member states to work in the public interest. They have empowered transnational corporations by giving them greater opportunities to exert undue influence in public health matters; by enabling them to 'bluewash' their tarnished public images through association with prestigious UN-sanctioned initiatives; and by creating corporatist decision-making structures in which transnational industries are privileged partners at the expense of public sector and civil society actors.

If WHO is to put public interests at the centre of all its global public-private interactions, it needs to tackle the following tasks:

1. abandon the partnership terminology;
2. clarify which categorisation of public-private interactions in health best allows for technical and conflict of interest assessment;
3. hold a public review and debate on the benefits, risks and costs of the different global public-private interactions in health when compared to alternatives;
4. encourage an open debate on the risks of the partnership paradigm for coherent, public-interest centred, international health policy making;
5. formulate an overall institutional policy for public-private interactions based on the review of existing knowledge in all relevant areas;
6. recover and further clarify the human rights and social justice principles underlying WHO's work towards Health for All;
7. build up effective and coherent safeguards that incorporate conflict of interest considerations;
8. formulate a public disclosure policy;
9. work for a clearer distinction between actors that represent and are closely linked to commercial interests and other societal actors;
10. encourage a similar process in other UN agencies.

The primary focus of any public policy and safeguard consideration must be how best to ensure the integrity and independence of WHO so that it can pursue its mandate and core missions, which include fostering democratic and public-interest centred decision-making structures and processes in a globalising world.

6. A strategy for Finland and like-minded countries

There are several ways in which Finland and like-minded countries could help ensure that public interests are safeguarded in international health policy-making.

Policies

- *Finland may wish to advocate a public assessment of the 'added value' (the comparative advantage of the benefits against the broad risks and costs) that are claimed for global public-private partnerships within the UN when compared with other possible collaborative arrangements.* This should include an assessment of the major legally independent global health alliances and partnerships with the pharmaceutical sector, looking in particular at their impact on decision-making processes in the international health arena.
- The protection of public health interests requires adequate and effective safeguards to be in place. *Finland may wish to join calls for an independent, external review of mechanisms to safeguard WHO's integrity and independence, including WHO's Guidelines for Interactions with Commercial Enterprises to Achieve Health Outcomes.* But care should be taken that such a review is not influenced by political pressures. Finland could organise a conference on the issue to bring together policy-makers, WHO (and other UN) officials, theoreticians in the field of conflicts of interest, political scientists and representatives of public health and public interest organisations and networks.
- *To ensure policy coherence, Finland may wish to advocate or initiate an independent review of the public interest safeguards in public-private interactions of other UN agencies* (in particular the various guidelines for collaboration and alliances with the business community of UNICEF, the United Nations, the UN Global Compact, UNFPA, UNAIDs, and the WHO/FAO Codex Alimentarius). Such a review should take a similar broad approach to that suggested for a review of WHO's safeguards; it should clarify the ethical basis of the interactions and safeguards and should bring conflict of interest considerations to the core of the process.
- *Finland and like-minded countries may wish to urge UN agencies to take more practical steps to fulfil their commitment of transparency and public disclosure with respect to public-private interactions.* They could request that the agencies post on their websites under specific headings, such as 'governance', 'policy documents' or 'UN-business interactions', all relevant institutional policies and guidelines, or all relevant global

PPIs and financial relationships that include UN agencies either as a participant or a promoter and any other relevant related information.

- If the debate on the WHO's proposed Policy for Relations between the World Health Organization and Nongovernmental Organizations is reopened, *Finland may wish to ensure that the definition of NGOs in the Policy does not positively identify actors representing commercial interests or close to the commercial sector as NGOs.*

Funding

- Adequate resources for the UN system need to be secured. This task has become more important than ever. The UN's financial security should not be undermined by channelling regular aid money to social experiment, high-level, public-private partnerships such as the global health alliances that follow the GAVI model and the Global Compact. *To ensure the integrity and capacity of WHO to fulfil its mandate, Finland may wish to reopen the debate on unfreezing member states contributions and investigating how funds can be secured without undue conditionalities being attached to them.*
- *Finland could fund public interest NGOs and academic institutions that monitor global public-private interactions and the corporations involved.* Such NGOs include, for example, the International Baby Food Action Network (IBFAN), Health Action International (HAI), the People's Health Movement (PHM), the Alliance for People's Action on Nutrition (APAN) and the Corporate Europe Observatory (CEO).

Annex 1: WHO Standards of Conduct and Financial Disclosure

July 1998

- All financial interests in the private sector, such as shareholdings or bond holdings, are to be declared in confidence to the Legal Counsel.

- Any patent interests are likewise to be declared.

- Any other private sector interest, such as paid or unpaid directorships (paid remuneration being clearly ruled out under existing rules) are likewise to be declared.

- Legal Counsel is to advise the Director-General on whether any holding or interest could give rise to a real or perceived conflict of interest and whether there should be a divestment, placement in trust or other administrative arrangement made with respect such holdings and interests.

- The proposal will apply to the Director-General, Cabinet Members and other senior officials as determined by the Director-General, together with their spouses and dependent children.

- There will be annual declaration [of the financial interests] with updating whenever there is a material change.

- These new rules will be formally incorporated into WHO staff rules after approval by the Executive Board at its next meeting, but their application will be immediate, by Cabinet decision.

- The issue of full financial disclosure will be reviewed in the context of UN developments and a more general ethics initiative.

Source: Director-General implements new code of conduct for financial disclosure, Press Release WHO/55, Annex 1, 21 July 1998

Annex 2: WHO's criteria for social responsibility screening

- ***Human rights*** e.g. information about:

1. Respect and protection of internationally proclaimed human rights by the company and subsidiaries.
2. Information about violation of human rights.

- ***Environmental record*** e.g. information as to whether:

1. Company has a record of violation of environmental laws or regulations.
2. Company's products or services are found to be damaging to the environment.
3. Company enforces programmes such as pollution reduction, recycling, conservation of energy and natural resources.
4. Company contributes to environmental causes.

- ***Labor rights*** e.g. information about:

1. Fair treatment of employees – non-violation of labor laws: forced, compulsory child labor, discrimination at workplace (gender, race).
2. Labor negotiations: how labor disputes are/have been solved.
3. Employee participation in management, cash profits stock ownership.
4. Frequency of strikes and disputes, fair notices of layoffs and closing plants.
5. Does the company respect freedom of association, collective bargaining as a right?

- ***Social Responsibility*** e.g. information on:

1. Corporate philanthropy and giving policies, community investment and community relations, amounts given to humanitarian causes and major recipients.

- ***Health*** e.g. information as to whether:

1. Products and/or services are safe and non-detrimental to health – any public health concerns, company compliance with international health standards.
2. Company has occupational health and safety policies both at HQ and subsidiaries.
3. Company has been sued for activities causing health hazards?
4. Measures taken in favor of maternal rights: breast-feeding room facilities, maternity leave.
5. Health-care provided for employees and in compliance with the industry sector standard?

- ***Ethical Information*** e.g.

1. Does the company manufacture or sell products related to alcohol, gambling, tobacco or arms?
2. Do company policies indicate fair recruitment and treatment of employees (minorities, women, maintaining people with health concerns)?
3. Does the company have an ethical code of conduct?
4. What are the R&D practices?
5. Are there indicators for strong ethical business dealings such as a code of ethics or a publicized anti-corruption policy?
6. Information about applied standards for suppliers.
7. Reporting:
   Does the company produce environmental or social report?

Source: Terms of Reference for Inter-Agency Corporate Information Tool, (Oct. 2001) Unpublished document prepared by the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the Office of the UN Secretary-General (UNOSG), and the World Bank in cooperation with United Nations Fund for International Partnership (UNFIP)

Annex 3: Transparency in tobacco control process

World Health Assembly Resolution 58.18

May 2001

The Fifty-fourth World Health Assembly,

Noting with great concern the findings of the Committee of Experts on Tobacco Industry Documents, namely, that the tobacco industry has operated for years with the expressed intention of subverting the role of governments and of WHO in implementing public health policies to combat the tobacco epidemic;[1]

Understanding that public confidence would be enhanced by transparency of affiliation between delegates to the Health Assembly and other meetings of WHO and the tobacco industry,

1. URGES WHO and its Member States to be alert to any efforts by the tobacco industry to continue this practice and to assure the integrity of health policy development in any WHO meetings and in national governments;

2. URGES Member States to be aware of affiliations between the tobacco industry and members of their delegations;

3. CALLS ON WHO to continue to inform Member States on activities of the tobacco industry that have negative impact on tobacco control efforts.

Ninth plenary meeting, 22 May 2001,
A54/VR/9

Source: Fifty-fourth World Health Assembly, Agenda item 13.5, WHA54.18, 22 May 2001, http://www.who.int/gb/ebwha/pdf_files/WHA54/ea54r18.pdf

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1 Tobacco company strategies to undermine tobacco control activities at the World Health Organization. Geneva, July 2000. http://www.who.int/genevahearings/inquiry.html.

Annex 4: Declaration of Interests for WHO Experts

Title of meeting or work to be performed, including description of subject-matter, substance (compounds and organisms), technology or process to be considered: _____

_____ _____

Public health considerations have a primary importance in all WHO technical work. Measures need to be taken to ensure that the best possible assessment of scientific evidence is achieved in an independent atmosphere free of either direct or indirect pressures. Thus, to assure the technical integrity and impartiality of WHO's work, it is necessary to avoid situations in which financial or other interests might affect the outcome of that work.

Each expert is therefore asked to declare any interests that could constitute a real, potential or apparent conflict of interest, with respect to his/her involvement in the meeting or work, between (1) commercial entities and the participant personally, and (2) commercial entities and the administrative unit with which the participant has an employment relationship. "Commercial entity" refers to any company, association (e.g., trade association), organization or any other entity of any nature whatsoever, with commercial interests.

In addition, as a result of WHO's strong stance against tobacco use, it is considered relevant for the Organization to know whether experts working with it have, or have had, any relationship with any part of what may be called "the tobacco industry". Nevertheless, declaration of such an interest would not necessarily be considered a reason to disqualify an expert.

What is a conflict of interest?
Conflict of interest means that the expert or his/her partner ("partner" includes a spouse or other person with whom s/he has a similar close personal relationship), or the administrative unit with which the expert has an employment relationship, has a financial or other interest that could unduly influence the expert's position with respect to the subject-matter being considered. An apparent conflict of interest exists when an interest would not necessarily influence the expert but could result in the expert's objectivity being questioned by others. A potential conflict of interest exists with an interest which any reasonable person could be uncertain whether or not should be reported.

Different *types of financial or other interests*, whether personal or with the administrative unit with which the expert has an employment relationship, can be envisaged and the following list, which is not exhaustive, is provided for your guidance. For example, the following types of situations should be declared:

1. a current proprietary interest in a substance, technology or process (e.g. ownership of a patent), to be considered in – or otherwise related to the subject-matter of – the meeting or work;

2. a current financial interest, e.g. shares or bonds, in a commercial entity with an interest in the subject-matter of the meeting or work (except share holdings through general mutual funds or similar arrangements where the expert has no control over the selection of shares);

3. an employment, consultancy, directorship, or other position during the past 4 years, whether or not paid, in any commercial entity which has an interest in the subject-matter of the meeting/work, or an ongoing negotiation concerning prospective employment or other association with such commercial entity;

4. performance of any paid work or research during the past 4 years commissioned by a commercial entity with interests in the subject-matter of the meetings or work;

5. payment or other support covering a period within the past 4 years, or an expectation of support for the future, from a commercial entity with an interest in the subject-matter of the meetings or work, even if it does not convey any benefit to the expert personally but which benefits his/her position or administrative unit, e.g. a grant or fellowship or other payment, e.g. for the purpose of financing a post or consultancy.

With respect to the above, an interest in a competing substance, technology or process, or an interest in or association with, work for or support by a commercial entity having a direct competitive interest must similarly be disclosed.

How to complete this Declaration: Please complete this Declaration and submit it to the Secretariat. Any financial or other interests that could constitute a real, potential or apparent conflict of interest should be declared (1) with respect to yourself or partner, as well as (2) with respect to the administrative unit with which you have an employment relationship. Only the name of the commercial entity and the nature of the interest is required to be disclosed, no amounts need to be specified (though they may be, if you consider this information to be relevant to assessing the interest). With respect to items 1 and 2 in the list above, the interest should only be declared if it is current. With respect to items 3, 4 and 5, any interest during the past 4 years should be declared. If the interest is no longer current, please state the year when it ceased. With respect to item 5, the interest ceases when a financed post or fellowship is no longer occupied, or when support for an activity ceases.

Assessment and outcome: The information submitted by you will be used to assess whether the declared interests constitute an appreciable real, potential or apparent conflict of interest. Such conflict of interest will, depending on the situation, result in (i) you being asked not to take part in the portion of the discussion or work affecting that interest, (ii) being asked not to take part in the meeting or work altogether, or (iii) if deemed by WHO to be appropriate to the particular circumstances, and with your agreement, you taking part in the meeting or work and your interest being publicly disclosed.

Information disclosed on this Form may be made available to persons outside of WHO only when the objectivity of the meeting or work has been questioned such that the Director-General considers disclosure to be in the best interests of the Organization, and then only after consultation with you.

Declaration: Have you or your partner any financial or other interest in the subject-matter of the meeting or work in which you will be involved, which may be considered as constituting a real, potential or apparent conflict of interest?

Yes: ☐ No: ☐ If yes, please give details in the box below.

Do you have, or have you had during the past 4 years, an employment or other professional relationship with any entity directly involved in the production, manufacture, distribution or sale of tobacco or any tobacco products, or directly representing the interests of any such entity?

Yes: ☐ No: ☐ If yes, please give details in the box below.

Type of interest, e.g. patent, shares, employment, association, payment (including details on any compound, work, etc.)	Name of commercial entity	Belongs to you, partner or unit?	Current interest? (or year ceased)

Is there anything else that could affect your objectivity or independence in the meeting or work, or the perception by others of your objectivity and independence?

_____

_____

I hereby declare that the disclosed information is correct and that no other situation of real, potential or apparent conflict of interest is known to me. I undertake to inform you of any change in these circumstances, including if an issue arises during the course of the meeting or work itself.

_____ _____

Signature Date

_____ _____

Name Institution

Source: http://www.who.int/medicines/library/par/gfg_declaration.doc, accessed 1 July 2004

References

Anello, E. (2001). Assessing conflict of interest, *Consultant report prepared for WHO. Unpublished document.* 21 June.

Annan, K. (1999). *Address of the Secretary-General Kofi Annan to the World Economic Forum in Davos*, Switzerland, 31 January 1999, www.un.org/partners/business/davos.htm, accessed 17 *January 2001.*

Babor, T.F., Griffith, E., & Stockwell, T. (1996). Science and the drinks industry: A cause for concern. *Addiction*, 91(1), pp. 5–9.

Balanyá, B., Doherty, A., Hoedeman, O., Ma'anit, A., & Wesselius, E. (2000). *Europe Inc.: Regional and global restructuring and the rise of corporate power* London: Pluto Press in Association with Corporate Europe Observatory (CEO).

Beigbeder, Y. (2004). *International public health: Patient rights vs. the protection of patents* Hants and Burlington: Ashgate.

Bellamy, C. (1999). Speech by Carol Bellamy, Executive Director, United Nations Children's Fund, to Harvard International Development, *Conference on 'Sharing responsibilities: Public, private & civil society,'* Cambridge, Massachusetts, 16 April.

Bøås, M. & McNeill, D. (Eds.) 2004. *Global institutions and development: Framing the world?* London & New York: Routledge.

Boseley, S. (2002). Unhealthy influence: There is a danger that WHO's new partnership with drug companies will skew its health politics, *The Guardian*, 6 February.

Boseley, S. (2003). Sugar industry threatens to scupper WHO, *The Guardian*, 21 April. www.guardian.co.uk/international/story/0,3604,940287,00.html; accessed 21 April 2004.

Brundtland, G.H. (1998). *Address by Dr. Gro Harlem Brundtland, Director-General, to the Fifty-First World Health Assembly.* Geneva: World Health Organization, 13 May.

Brundtland, G.H. (2002a). *Address by Dr. Gro Harlem Brundtland, Director-General, to the Fifty-Fifth World Health Assembly* Geneva: World Health Organization, 13 May.

Brundtland, G.H. (2002b). *WHO/IFPMA Roundtable: Opening remarks* Geneva: WHO, Office of the Director-General, 20 February.

Bruno, K., & Karliner, J. (2000). *Tangled up in blue: Corporate partnerships in the United Nations* San Francisco: Transnational Resource & Action Centre (TRAC).

Bruno, K., & Karliner, J. (2002). *earthsummit.biz: The corporate take-over of sustainable development* Oakland, California: Food First Books.

Buse, K., & Walt, G. (2000a). Global public-private partnerships: part II – what are the health issues for global governance? *Bulletin of the World Health Organization – The International Journal of Public Health*, 78 (5), pp. 699–709.

Buse, K., & Walt, G. (2000b). Global public-private partnerships: part I – a new development in health? *Bulletin of the World Health Organization – The International Journal of Public Health*, 78(4), pp. 549–561.

Buse, K., & Walt, G. (2002). Globalisation and multilateral public-private health partnerships: Issues for health policy. In K. Lee, K. Buse, & S. Fustukian (Eds.), *Health policy in a globalising world.* Cambridge: Cambridge University Press, pp. 41–62.

Buse, K., & Waxman, A. (2001). Public-private health partnerships: A strategy for WHO. *Bulletin of the World Health Organization*, 79(8), pp. 748–754.

Cabasse, C. (2004). Brevets: dix années passées sous la férule des laboratoires. *Le Monde Diplomatique*, Manière de voir (73), March–April, p. 71.

Chetley, A. (1986). *The politics of baby foods: Successful challenges to an international marketing strategy* London: Frances Pinter Publishers.

Chetley, A. (1990). *A healthy business? World health and the pharmaceutical industry* London: Zed Books Ltd.

CI/HAI/IBFAN (2001). Guidelines on Working with the Private Sector to Achieve Health Outcomes, *Statement made on behalf of Consumers International, Health Action International, the International Baby Food Action Network on agenda item 8.3, World Health Assembly,* May.

CI/HAI/IBFAN (2002). Public Private Interactions for Health: WHO's Involvement, *Statement made on behalf of Consumers International, Health Action International, International Baby Food Action Network, on agenda item 3.2, 109th Executive Board Meeting, Geneva, 14 January 2002.*

CI et al. (2004). Statement on behalf of Consumers International, the International Baby Food Action Network, the People's Health Movement, and the International People's Health Council on agenda item 21, *World Health Assembly May 2004.*

Clark, K. (2001). Regulating the conflict of interest of government officials. *In M. Davis, & A. Stark (Eds.), op. cit.,* pp. 49–60.

CMH (2001). *Macroeconomics and health: Investing in health for economic development. Report of the Commission on Macroeconomics and Health* Geneva: World Health Organization.

Coote, A. (2002). Charity is old-fashioned and stuffy. Venture philanthropy is cool, *The New Statesman.*

Davis, M. (1998). Conflict of interest. In R. Chadwick (Ed.), *Encyclopedia of Applied Ethics.* San Diego/London/Boston/New York/Sydney/Tokyo/Toronto: Academic Press, pp. 589–596.

Davis, M. (2001). Introduction. In M. Davis, & A. Stark (Eds.), *op. cit.,* pp. 3–19.

Davis, M., & Stark, A. (2001). *Conflict of interest in the professions.* Oxford and New York: Oxford University Press.

DIFID (2002). *Working in partnership with the World Health Organization (WHO): Institutional strategy paper* London: Department for International Development (DIFID), August.

ECOSOC (1996). *Consultative relationship between the United Nations and non-governmental organizations. Resolution 1996/31.* Economic and Social Council.

Emmerij, L., Jolly, R., & Weiss, G.T. (2001). *Ahead of the curve? UN ideas and global challenges* Bloomington and Indianapolis: Indiana University Press.

EU (2004). *Statement by the Irish Presidency on behalf of the European Union in response to agenda item 12.6 Draft Global Strategy on diet, physical activity and health, 57th World Health Assembly.* Geneva, 17–22 May.

Gellman, B. (2000a). An unequal calculus of life and death: As millions perished in pandemic, firms debated access to drugs, *The Washington Post,* 27 December, p. A01.

Gellman, B. (2000b). A turning point that left millions behind: Drug discounts benefit few while protecting pharmaceutical companies' profit, *The Washington Post,* p. AO1.

Giovanni, A.C., Jolly, R., & Stewart, F. (1987). Adjustment with a human face. Oxford: Clarendon Press.

HAI (1999). *Letter from Bas van der Heide, Coordinator HAI-Europe to Denis Aitken, Chair, WHO Committe on Private Sector Collaboration.* Amsterdam: 22 December.

HAI (2000). *Public/private partnerships: Meeting real health needs? Conference Reader,* Kapellerput, The Netherlands, 3 November: Health Action International (HAI-Europe), BUKO Pharma-Kampagne, Amsterdam and Bielefeld.

HAI (2001). WHO's growing 'partnership' with the private sector: Addressing public health needs or corporate priorities?, *Briefing paper, 54th World Health Assembly, May 2001*: Health Action International.

HAI et al. (1999). Public interest NGOs raise concerns about industry sponsorship of WHO: Will WHO be able to bite the hand that feeds it? *Press Release.* HAI, Act-Up Paris, Consumer Project on Technology, Fondation du Présent, INFACT, International Baby Food Action Network, International Federation of Health Records Organizations, 19 May.

Hayes, L. (2001). Industry's growing influence at the WHO, *Presentation at Panel discussion on Global Compact with corporations: 'Civil society' responds. Organised by Global Policy Forum, 15 February 2001.* New York: Global Policy Forum, www.globalpolicy.org/reform/2001/0223who, accessed 12 June 2004.

Heimans, J.J. (2002). *Multisectoral global funds as instruments for financing spending on global priorities*, DESA Discussion Paper Series. New York: United Nations Department of Economic and Social Affairs (DESA), www.un.org/esa/papers.

Hirschhorn, N. (2002). *How the tobacco and food industries and their allies tried to exert undue influence over FAO/WHO food and nutrition policies.* New Haven, Connecticut USA: Consultancy report to WHO (unpublished document).

Horton, R. (2002a). WHO: The casualties and compromises of renewal. *The Lancet*, 359, 4 May, pp. 1605–1611.

Horton, R. (2002b). WHO's mandate: A damaging reinterpretation is taking place – Commentary. *The Lancet*, 360, 28 September, p. 9338.

IBFAN/ICDC (2004). *Breaking the rules, stretching the rules 2004: Evidence of violations of the International Code of Marketing of Breastmilk Substitutes and subsequent resolutions* Penang: International Baby Food Actions Network/International Code Documentation Centre.

IBFAN (1999). *Comments on WHO Guidelines on Interactions with Commercial Enterprises (preliminary version July 1999)*: International Baby Food Action Network, posted on www.haiweb.org/news/ibfancomments.html.

IBFAN et al. (2003). Summary of key NGO concerns regarding the proposed WHO policy for relations with nongovernmental organisations, *Briefing note*: International Baby Food Action Network (IBFAN), Health Action International (HAI), INFACT, Peoples Health Movement (PHM) and International People's Health Council (IPHC), October.

ICC (1998). *The Geneva Business Declaration.* Statement by Helmut O. Maucher, President of the International Chamber of Commerce (ICC), at the conclusion of the Geneva Business Dialogue. Geneva, 24 September.

ICC (2000). Business supports Kofi Annan's Global Compact but rejects 'prescriptive' rules, *Press Release, International Chamber of Commerce (ICC).* Budapest, 4 May. Quoted in Buse and Walt, 2002.

ICC/IOE (2003). *Joint written statement submitted by the International Chamber of Commerce (ICC) and the International Organization of Employers (IEO), non-governmental organizations in general consultative status*: Commission on Human Rights, Sub-Commission on Promotion and Protection of Human Rights, Item 4, Economic, Social and Cultural Rights, Doc. E/CN.4/Sub.2/2003/NGO/44, 24 July.

Infact (2004). *Infact intervention to the 113th Session of the WHO Executive Board, Agenda item 7.4: Policy for Relations with Nongovernmental Organizations.* January.

ISDI (2003). *WHA Draft Policy for Relations with Nongovernmental Organisations, EB111/22, Statement by the International Special Dietary Foods Industry (ISDI) to the WHA, May 2003.* www.ifm.net/legislation/statements/statement132003, accessed 10 June 2004.

ISDI (2004a). *ISDI Statement on NGO Relations to the WHO Executive Board, January 2004* www.ifm.net/legislation/statements/statement012004, accessed 10 June 2004.

ISDI (2004b). *ISDI Statement on Policy for relations with nongovernmental organizations to the World Health Assembly, May 2004* www.ifm.net/legislation/statements/statement052004b, accessed 10 June 2004.

Kettler, H., White, K., in consultation with Scott Jordan (2003). *Valuing industry contributions to public-private partnerships for health product development* Geneva: Initiative on Public-Private Partnerships for Health (IPPPH) Global Forum for Health Research (GFHR).

Kickbusch, I., & Quick, J. (1998). Partnerships for health in the 21st century. *Rapport trimestriel statistique sanitaire mondiale,* (51), pp. 68–74.

Krimsky, S. (2003). *Science in the private interest: Has the lure of profits corrupted biomedical research?* Lanham, Boulder, New York, Oxford: Rowman & Littlefield Publishers, Inc.

Lee, J.W. (2003). WHO leadership contest: Resources should be decentralised to countries and regions, *British Medical Journal, full online answer,* 18 January, http://bmj.bmjjournals.com/cgi/content/full/326/7381/123/a/DC1, accessed 29 April 2004.

Lohmann, L. (1990). Whose common future? *The Ecologist*, 20(3), pp. 82–84.

Martens, J. (2003). *The future of multilateralism after Monterrey and Johannesburg* Berlin: Friedrich Ebert Stiftung.

McKinsey&Company (2004). *Assessing the Global Compact's impact.* 11 June, www.unglobalcompact.org, accessed 11 June 2004.

Mezzalama, F., & Ouedraogo, L.D. (1999). *Private sector involvement and cooperation with the United Nations System* Geneva: Joint Inspection Unit (JIU), JIU/REP/99/6.

Motchane, J.-L. (2002). Health for All or riches for some: WHO's responsible?, *Le Monde Diplomatique* (English language version of: Droits des brevets ou droit a la santé? Quand l'OMS épouse la cause des firmes). July.

Nelson, J. (2002). *Building partnerships: Cooperation between the United Nations system and the private sector.* Report commissioned by the United Nations Global Compact. New York: United Nations Department of Public Information.

New, W. (2000). Special report: NGOs wary of UN corporate links, *UN Wire.* 26 May.

Ollila, E. (2003). Alma Atan julistus henkitoreissaan. In Rönnberg, L. & Simpura, J. (Eds.), *Pirstoutuva globaalinen terveyspolitiikka* (pp. 138–145). ICSW ja Sosiaali- ja terveysturvan keskusliitto.

Ollila, E. (2003b). *Global-health related public-private partnerships and the United Nations, Policy Brief No.2,* Helsinki:Globalism and Social Policy Programme (GASPP). Online version: www.gaspp.org/publications.

Ollila, E. (2003c). Health-related public-private partnerships and the United Nations. In B. Deacon, E. Ollila, M. Koivusalo, & P. Stubbs (Eds.), *Global social governance: Themes and prospects.* Helsinki: Ministry for Foreign Affairs of Finland, Department for International Development Cooperation, pp. 36–73. www.gaspp.org/publications.

Ollila, E. (2004). Restructuring global health policy making: The role of global public-private partnerships. In Koivusalo, M. & Mackintosh, M. (Eds.), *Commercialisation of health care: global and local dynamics and policy responses.* Basingstoke: Palgrave. *Forthcoming.*

Piore, A. (2002). Charities that hate to just 'give': Venture philanthropists bring business models, jargon and demands to the job of saving us all from cancer, asteroids, you name it. *Newsweek*, 4 February, p. 37.

Prescire International (1999). Our correspondence with the World Health Organzation about the hypertension guidelines. *Prescrire International*, (44), 8 December, pp. 190–191.

Quick, J. (2001). Partnerships need principles. *Bulletin of the World Health Organization*, 79 (8), p. 776.

Reymond, J.-M., & Philippin, E. (2003). *Collaborating with the private sector: The conflict of interest issue* (Power point slide series for WHO) Lausanne: Carrard Paschoud Heim & Partners.

Richter, J. (2001). *Holding corporations accountable: Corporate conduct, international codes, and citizen action* London and New York: Zed Books.

Richter, J. (2003a). Global public private 'partnerships': How to ensure that they are in the public interest? *SCN News* (26), July, pp. 8–11.

Richter, J. (2003b). *'We the peoples' or 'we the corporations'? Critical reflections on UN-business 'partnerships'* Geneva: Geneva Infant Feeding Association/International Baby Food Action Network (GIFA-IBFAN), Online version www.ibfan.org/english/news/press/press20jan03.

Rodwin, M.A. (1993). *Medicine, money and morals: Physicians' conflicts of interest* New York and Oxford: Oxford University Press.

Rodwin, M.A. (2003). E-mail communication with the author.

Rodwin, M.A. (2004). E-mail communication with the author.

Rundall, P. (2000). The perils of partnership: An NGO perspective. *Addiction*, 95 (10), October, pp. 1501–1504.

SID/WHO/ISS (2000). Report on the International Seminar on 'Global Public-Private Partnerships for Health and Equity', *Occasional Paper* (unpublished) Rome: Society for International Development (SID), World Health Organization (WHO), Istituto Superiore di Sanità (ISS).

South Centre (1997). *For a strong and democratic United Nations: A South perspective.* Geneva: South Centre.

Stark, A. (2000). *Conflict of interest in American public life* Cambridge, MA: Harvard University Press.

Starling, M., Brugha, R., Walt, G., Heaton, A., & Keith, R. (2002). *New products into old systems: the initial impact of the Global Alliance for Vaccines and Immunizations from a country perspective* London: Save the Children, UK (SCF).

Sustainability (2003). *The 21st Century NGO: In the market for change* London, New York, Paris: Sustainability, The Global Compact & UNEP.

Taylor, I. (2004). Hegemony, neoliberal 'good governance' and the International Monetary Fund: A Gramscian perspective. In M. Bøås, & D. McNeill (Eds.), *Global institutions and development: Framing the world?* London and New York: Routledge, pp. 124–136.

Tesner, S., with the collaboration of Georg Kell (2000). *The United Nations and business: A partnership recovered* New York: St. Martin's Press.

UN (2000). *Guidelines on Cooperation between the United Nations and the Business Community.* New York: Issued by the Secretary-General of the United Nations, 17 July. www.un.org/partners/business/otherpages/guide, accessed 4 February 2004.

UN (2001). Cooperation between the United Nations and all relevant partners, in particular the private sector. *Report of the Secretary-General to the General Assembly. Item 39 of the provisional agenda: Towards global partnerships. UN Doc.* A/56/323. New York, 28 August.

UN (2003a). *The diversity of actors within the UN System.* Mimeo. Website: Panel of Eminent Persons on UN-Civil Society Relations. www.un.org/reform/pdfs/categories.htm, accessed 11 June 2004.

UN (2003b). Enhanced cooperation between the United Nations and all relevant partners, in particular the private sector, *Report of the Secretary-General to the General Assembly. Item 47 of the provisional agenda: Towards global partnerships.* Un Doc. A/58/227. New York, 18 August.

UN (2003c). *Global Compact networks.* Website: UN Global Compact Office website. www.unglobalcompact.org, accessed 16 June 2004.

UN (2003d). *Global Compact outreach events.* Website: UN Global Compact Office, www.unglobalcompact.org/irj/servlet/prt/portal/prtroot/com.sapportals.km.docs/

ungc_html_content/Outreach/or_event, accessed 16 April 2004.

UN (2004). Workshop summary: Multi-stakeholder Workshop on Partnership and UN-Civil Society Relationships, *Pocantico Conference Center of the Rockefeller Brothers Fund, Tarrytown, New York.* Website: Panel of Eminent Persons on UN-Civil Society Relations, www.un.org/reform/pocantico_final.doc, accessed 11 June 2004.

UNICEF (2001a). *Building Alliances for Children: UNICEF Guidelines and Manual for Working with the Business Community – Identifying the Best Allies, Developing the Best Alliances.* New York: United Nations Children's Fund (unpublished document).

UNICEF (2001b). *Building Alliances for Children – Summary. UNICEF Guidelines for Working with the Business Community – Identifying the Best Allies, Developing the Best Alliances* New York: UNICEF (unpublished document).

Utting, P. (2000). *Business responsibility for sustainable development* Geneva: United Nations Research Institute for Social Development (UNRISD).

Utting, P. (2002). Regulating business via multistakeholder inititatives: A preliminary assessment. In *Voluntary approaches to corporate responsibility – Readings and a resource guide. NGLS Development Dossier.* Geneva: UN Non-Governmental Liaison Service/United Nations Research Institute for Social Development NGLS/UNRISD, pp. 61–126.

Velásquez, G. (2004). Les médicaments, un bien publique mondial?, *Le Monde Diplomatique,* March–April, pp. 67–70.

Waxman, A. (2000). Why public-private partnerships for health? Opportunities and challenges for the World Health Organization (WHO), *Background paper for the SID-WHO-ISS Seminar on Global public-private partnerships for health and equity (informal paper prepared for discussion at the seminar,* revised version*).* Rome, 23-24 November.

Waxman, A. (2003). Panel on UN-business partnerships, *Conference on Corporate social responsibility and development: Towards a new agenda?* Organized by the United Nations Research Institute for Social Development (UNRSID), Geneva, Palais des Nations, 17–18 November. www.unrisd.org. Click Presentations, pp.43–45.

WHO (1987). *Principles Governing Relations between the World Health Organization and Nongovernmental Organizations.* Resolution WHA40.25, Reprinted in WHO Basic Documents, 44th ed., Geneva: WHO (2003), pp. 77–82.

WHO (1993) *Health development in a changing world: A call for action.* Resolution WHA46.17, Forty-sixth World Health Assembly. Geneva: World Health Organization.

WHO (1997) Draft: Partnerships for health in the 21st century. 2 + 2 = 5, *Working paper submitted by the Working Group on Partnerships at the WHO/HQ in the context of the Health for All renewal.* Geneva: WHO, July.

WHO (1998) Director-General implements new code of conduct for financial disclosure, *Press Release WHO/55.* 21 July. www.who.int/inf-pr-1998/en/pr98-55.html, accessed 13 April 2004.

WHO (1999a) *A corporate strategy for the WHO Secretariat: Report by the Director-General,* EB 105/3. Geneva: World Health Organization.

WHO (1999b) *Letter of Denis Aitken, Chair, WHO Committee on Private Sector Collaboration to Bas van der Heide, then coordinator or Health Action International-Europe.* 11 October.

WHO (1999) *WHO Guidelines on Interaction with Commercial Enterprises* Geneva: World Health Organization, preliminary version July 1999.

WHO (2000a) Declaration of interests for WHO experts. Geneva: World Health Organization. Unpublished document, 21 September www.who.int/pcs/ra_site/docs/Declaration_of_interest.pdf (Pdf version), accessed June 2004.

WHO (2000b) *Guidelines on interaction with commercial enterprises to achieve health outcomes. Annex to Report by the Secretariat.* Geneva: *WHO Doc.* EB107/20, 30 November www.who.int/gb/ebwha/pdf_files/EB107/ee20.pdf, accessed May 2004.

WHO (2000c) *Guidelines on working with the private sector to achieve health outcomes: Report by the Secretariat.* Geneva: WHO Doc. EB107/20, 30 November 2000 www.who.int/gb/EB_WHA/PDF/EB107/ee20.pdf, accessed 8 Nov. 2002.

WHO (2000d) *List of comments received on Guidelines on interaction with commercial enterprises* Geneva: WHO (unpublished document).

WHO (2000e) *Tobacco company strategies to undermine tobacco control activities at the World Health Organization: Report of the Committee of Experts on Tobacco Industry Documents.* Geneva: WHO, July.

WHO (2001) *Public-private interactions for health: WHO's involvement. Note by the Director-General.* Geneva: WHO Doc. EB109/4, 5 December, www.who.int/gb/EB_WHA/PDF/EB109/eeb1094.pdf.

WHO (2002) Policy for relations between the World Health Organization and nongovernmental organizations, *Annex to Policy for relations with nongovernmental organizations: Report by the Director-General.* Geneva: WHO Doc. EB111/22, 25 November, pp. 5–7.

WHO (2003a) Core values for a global health partnership, *The World Health Report 2003: Shaping the future.* Geneva: WHO, pp. xi–xii.

WHO (2003b) *Executive Board, 111th Session, Summary Records* Geneva: WHO Doc EB111/2003/REC/2.

WHO (2003c). Policy for relations between the World Health Organization and nongovernmental organizations, *Annex to Policy for relations with nongovernmental organizations: Report by the Director-General* pp. 5–7. Geneva: WHO Doc. A56/46, 14 April.

WHO (2004a) *Collaboration with nongovernmental organizations: Report of the Standing Comittee on Nongovernmental Organizations* Geneva: WHO Doc. EB113/23, 23 January.

WHO (2004b) *Policy for relations with nongovernmental organizations: Note by the Director-General.* Geneva: WHO Doc. A57/32, 1 April, www.who.int/gb/ebwha/pdf_files/WHA57/A57_32-en.pdf, accessed 9 June 2004.

WHO/CSI (2001) *Strategic alliances: The role of civil society in health* Geneva: WHO Civil Society Initiative, External Relations and Governing Bodies, Doc. CSI/2001/DP1, December.

WHO/CSI (2002) *WHO's interactions with civil society and nongovernmental organizations: Review Report* Geneva: WHO Civil Society Initiative, External Relations and Governing Bodies, Doc. WHO/CSI/2002/WP6.

Williams, S. (1985) *Conflicts of interest: The ethical dilemma in politics* Aldershot: Gower.

Woodman, R. (1999) Open letter disputes WHO hypertension guidelines. *British Medical Journal (BMJ)*, 318, 3 April, p. 893.

Yamey, G. (2002a) WHO in 2002: Faltering steps towards partnerships. *BMJ*, 325, 23 November, pp. 1236–1240.

Yamey, G. (2002b) WHO in 2002: Have the latest reforms reversed WHO's decline? *BMJ*, 325, 9 November, pp. 1107–1112.

Yamey, G. (2002c) WHO in 2002: WHO's management – struggling to transform a 'fossilised' bureaucracy. *BMJ*, 325, 16 November, pp. 1170–1173.

Zammit, A. (2003) *Development at risk: Rethinking UN-business partnerships* Geneva: UNRISD in collaboration with South Centre. Online version available from www.unrisd.org.

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Public-private partnerships (PPPs) are promoted as the innovative policy model of the new millennium. Should we be concerned about the rush into closer relationships with business? What are the effects of this policy on the decision-making powers of nation states and the UN system? Will transnational corporations use these new channels to exert more influence in public affairs? What safeguards are in place to protect democratic and participatory decision-making?

This publication summarises the findings of a review of the development of public interest safeguards in the health arena with a focus on the World Health Organization. It explores challenges to the establishment of an effective system to enable WHO to deal with conflicts of interest and other risks linked to the relationships between public and business-interest actors. A lack of space for open discussion about the new policy paradigm is identified as a key obstacle.

This publication makes a contribution to candid public debate. It argues for a re-examination of safeguards of other UN institutions, such as UNICEF. It proposes another look at such high-level arrangements as the legally-independent global health PPPs and the UN Secretary-General's Global Compact initiative. It presents suggestions of ways to strengthen the UN system's integrity and independence to fulfil its role in international health policy making and public interest advocacy.

ELEMENTS for DISCUSSION

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